Student Health Services
Division of Student Affairs
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www.fau.edu/shs

2016 – 17 Inactivated Influenza Vaccine Consent Form

SECTION A:

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Z Number: _____ Phone: _____

Are you: ☐ FAU Faculty ☐ FAU Staff ☐ Spouse/Partner

SECTION B:

1. Are you sick today? If yes, please explain: _____	☐ Yes	☐ No
2. Do you have allergies to medications, food (eggs), or any vaccine? If yes, please list: _____	☐ Yes	☐ No
3. Have you ever had a serious reaction after receiving a vaccination? If yes, please explain: _____	☐ Yes	☐ No
4. Do you have a history of Guillain-Barré Syndrome?	☐ Yes	☐ No

Healthcare Provider: Review any of the above "yes" answers with an RN/Clinician and record the instructions. Always confirm the standing order, manufacturer and standard doses with package insert.

SECTION C:

I have read the Centers for Disease Control (CDC) Vaccine Information Statement "Influenza (Flu) Vaccine (Inactivated or Recombinant): What You Need to Know" (8/7/2015) and have had an opportunity to ask questions. I understand the risks and benefits of the vaccine, and consent to vaccination with Inactivated Influenza vaccine. I agree to stay in Student Health Services for a period of 15 minutes following my injection.

I agree to hold Florida Atlantic University, its Board of Trustees, Student Health Services and all of their directors, employees, officers, representatives, agents and volunteers harmless from any and all liability and responsibility whatsoever for any damages, claims or causes of action, should an unforeseen, adverse or untoward event occur that may result in personal or bodily illness, injury or death from the administration of the Inactivated Influenza vaccine. I hereby voluntarily assume all risks and hazards that may arise from the administration of this vaccine and consent to receive this vaccine.

_____
Signature Date

SECTION D: *(To be completed by Healthcare Professional)*

☐ Influenza (Flu) Vaccine (Inactivated or Recombinant) Information Sheet (8/7/2015) given to patient.

Vaccine Type	Vaccine Name & Manufacturer	Lot #	Expiration Date:	Dose & Route of Injection	Injection Site/Deltoid (Circle One)	VIS Date
☐ Seasonal Influenza	Fluzone Intradermal Quadrivalent / Sanofi Pasteur	**UT5572AA**	**30 JUNE 2017**	0.1mL / Intradermal	R or L	8/7/2015
☐ Seasonal Influenza	Fluzone High-Dose / Sanofi Pasteur	**UI728AA**	**30 JUNE 2017**	0.5mL/Intramuscular	R or L	8/7/2015

_____
Signature of Healthcare Provider Title Date