Lincoln Medical Partners

INACTIVATED INFLUENZA VACCINE (injection) CONSENT & ADMINISTRATION FORM 2019-2020

CLIENT, PLEASE COMPLETE THIS SECTION:

Name (please print): _____DOB: _____AGE: _____

☐ **Employee** ☐ **Volunteer** ☐ **Other** _____ **Social security #** _____

Employer: _____ **Job Title:** _____

Medical history:

Serious allergy to eggs/egg products	☐ No	☐ Yes	explain: _____
Serious allergy to thimerosal, latex or vaccine ingredient	☐ No	☐ Yes	explain: _____
History of Guillain-Barre Syndrome	☐ No	☐ Yes	explain: _____
Fever or feeling ill today	☐ No	☐ Yes	explain: _____

(Vaccine may not be indicated if you have any "Yes" responses to the above)

CONSENT:

I have read or had explained to me the Centers for Disease Control: Influenza Vaccine "What You Need to Know", version 8/07/2015. (For inactivated or recombinant influenza vaccine). I have had a chance to have questions answered to my satisfaction. I understand the benefits and risks of receiving the influenza vaccine. I feel well and request the influenza vaccine be given to me today. I agree to wait near the vaccine clinic medical providers for at least 10 minutes after the vaccine is administered in the event of an allergic reaction.

Employee Signature for Consent: _____ **Date:** _____

Printed Name for Consent: _____

Insurance Information

Guarantor's Name: _____ **Guarantor's DOB:** _____

Guarantor's Mailing Address: _____ **Guarantor's Phone Number:**

_____ _____

_____

Name of Insurance Company: _____ **Insurance Effective Date:** _____

ID/Certificate #: _____ **Group #:** _____

STOP: Healthcare provider to complete below:

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Identity confirmed by: ❒ Workplace ID ❒Driver's license ❒ Other_____

2018-2019 Inactivated Influenza Vaccine 0.5 ml administered IM in deltoid: RIGHT ❒ LEFT ❒

Influenza Virus Vaccine: **Manufacturer:** **Lot #** **Expires:**

Department/Unit where vaccine administered: _____

Vaccine deferred ❒ Reason: _____