BARNES CENTER AT THE ARCH HEALTH Rx#___________

NAME ___________________________________ Date of Birth ______________________________

Phone (_____) ____________________________ SUID# ____________________________

CONSENT TO ADMINISTER SEASONAL INFLUENZA ("FLU") VACCINE 2021-22

Note:
Seasonal flu vaccine contains non-infectious killed viruses and cannot cause influenza. It is intended to provide protection against illness due to certain seasonal influenza viruses only. Adverse events associated with this vaccine should be reported immediately to your health care provider. Annual revaccination is recommended. This vaccine provides protection against three strains of influenza virus including the H1N1 flu virus.

Please read the Vaccine Information Statement for *Inactivated Influenza Vaccine (2021-22)*. Providing you an opportunity to this review this information is a Federal requirement. Take a copy if you wish.

***Please answer these questions carefully**:*
NOTE: You should not receive the flu vaccine if you have ever had a serious allergic reaction to eggs, thimerosal preservative, or to a previous immunization with flu vaccine, if you have a history Guillain-Barre Syndrome, or are pregnant.

	Question	YES	NO
1.	Is this your first flu vaccine injection ever?	_______	_______
2.	Do you have a past history of a reaction after the administration of any vaccine? Describe____	_______	_______
3.	Have you ever had a serious reaction to chicken eggs or egg protein?	_______	_______
4.	Do you have a history of Guillain-Barré syndrome? (A severe neurological disorder).	_______	_______
5.	Is it possible you could be pregnant?	_______	_______

I have answered this questionnaire to the best of my ability.
I have read the Vaccine Information Statement for *Inactivated Influenza Vaccine dated 8/6/2021*.
I have been given an opportunity to ask questions.
I believe I understand the benefits and risks of the influenza vaccine and request it be given to me.
I understand that it is up to me to inform my primary health care provider that I received this vaccine.
I further authorize Syracuse University Health Services as applicable to submit a claim to my insurance for the above requested items and services and request payment of authorized benefits to be made on my behalf to Syracuse University Health Services. I understand that I will be responsible for any co-sharing amounts including co-pays.

Patient Signature: ____ Date: __________

FOR HEALTH SERVICES USE:

Influenza vaccine/Mfg/Lot/Exp date: **LEFT ARM / RIGHT ARM**

COMMENTS:____

Signature____ **Date**__________________________