WHITMAN COLLEGE
Influenza Vaccine Consent Form 2018

PLEASE FILL ON LINE – AND THEN PRINT and take this form with you for your flu vaccine.

Name: (Last)_____ (First)_____

Date of Birth _____ Faculty/Staff_____ Other_____ Bon Appetit Employee_____

Whitman ID Number: _____Work Phone_____

You should not receive the Influenza vaccine if: You have ever had a serious allergic reaction to eggs, thimerosal preservative, or to a previous dose of influenza vaccine; you have a history of Guillain-Barre Syndrome (GBS); and/or you are ill.

Possible reaction(s):

Mild: Soreness or redness at the site of the shot; fever; body aches.

Severe: Acute allergic reaction – high fever; confusion; difficulty breathing; hives; rapid heartbeat – would occur within a few minutes of the shot). Guillain-Barre Syndrome – progressive muscle weakness and paralysis –may occur a week after the vaccine - (occurs in no more than 1-2 cases per million persons vaccinated).

Are you ill or have a fever? (answer on the day you go for the vaccine)	☐ Yes ☐ No
Are you allergic to eggs?	☐ Yes ☐ No
Are you allergic to thimerosal (used as a preservative in vaccines)?	☐ Yes ☐ No
Have you ever had a severe reaction to a flu vaccine?	☐ Yes ☐ No
Have you had Guillain-Barre Syndrome?	☐ Yes ☐ No
Are you allergic to Latex?	☐ Yes ☐ No
Are you pregnant or trying to become pregnant? (If YES, see your own doctor)	☐ Yes ☐ No

Consent **I have read the Influenza vaccine information sheet dated 8/07/15. I have been provided an opportunity to ask questions about the disease and the treatment. I understand the risks and benefits of the vaccination. I understand that the vaccination that I am about to receive is a single shot and it will not be fully effective for approximately two weeks. However, as with all vaccines there is no guarantee that I will become immune or that I will not experience side effects. I understand that I should not receive this vaccine if I have allergy to eggs, have had a severe reaction to a previous Influenza vaccine, allergy to thimerosal, or if I have had Guillain-Barre Syndrome. I hereby consent to have the influenza vaccine.**

Signature of vaccine recipient: Date:

OFFICE USE ONLY

Name of Flu vaccine: Flucelvax **Lot #: 252233** **Expiration Date: 05/31/19** **VIS Date: 8/7/2015**	**Name of Flu Vaccine: Flucelvax** **Lot # 252234** **Expiration Date: 06/30/19** **VIS Date: 8/7/15**
Dose: 0.5 cc. IM Location: ☐ R Deltoid ☐ L Deltoid	Health Center Location ☐ Cordiner Hall Foyer ☐
Datatel: _____ No Charge____ Paid: Check___ Cash____Chrg.____	Administered By: _____, RN Date: