

**State University of New York at Fredonia
LoGrasso Hall Health Center
Seasonal Influenza Immunization Screening and Consent Form**

Name (Please Print)	Date of Birth	Age	Date of Immunization
Address	City	State	Zip Code
Local Address	Phone Number	Gender	

Parent /Guardian (Please Print)	Mother's Maiden Name (Required if under 19 years of Age)
Family Physician	Family Physician Address

Indications	Have you (your child) had any vaccine within the last 28 days, including the 2009 H1N1 flu vaccine?	<input type="radio"/> Yes	<input type="radio"/> No
	Are you (your child) between 6 months and 24 years of age?	<input type="radio"/> Yes	<input type="radio"/> No
	Do you work in health care or emergency medical services?	<input type="radio"/> Yes	<input type="radio"/> No
	For ages 25-64 years, do you have a chronic or immunosuppressive medical condition?	<input type="radio"/> Yes	<input type="radio"/> No
	Are you pregnant?	<input type="radio"/> Yes	<input type="radio"/> No
	Are you a household contact or caregiver for children younger than 6 months of age?	<input type="radio"/> Yes	<input type="radio"/> No
Contraindications	Are you sick with a fever today?	<input type="radio"/> Yes	<input type="radio"/> No
	Have you ever had a serious reaction to the nasal spray or flu shot vaccine?	<input type="radio"/> Yes	<input type="radio"/> No
	Do you have a severe allergy to eggs, severe allergy to a component of the vaccine, or an anaphylactic allergy to latex?	<input type="radio"/> Yes	<input type="radio"/> No
	Have you ever had Guillain Barre' Syndrome?	<input type="radio"/> Yes	<input type="radio"/> No

Influenza Consent

I have read, or had explained to me, the Vaccine Information Sheet (VIS) about Seasonal influenza vaccination. I have had a chance to ask questions which were answered to my satisfaction and I understand the benefits and risks of the vaccination as described. I request that Seasonal influenza vaccination be given to me (or the person named above whom I am authorized to make this request).

Signature of Recipient (parent or guardian)

Date

Area Below to be Completed by Vaccinator

Administration site: Left Deltoid Right Deltoid Left Thigh Right Thigh

(Dosage is 0.5 ml) **VIS Date** _____ **Manufacturer & Lot Number** _____

Vaccinator Signature _____