University of Rochester | University Health Service

For UHS use only

INACTIVATED INFLUENZA VACCINATION CONSENT FOR 2020-21, Quadrivalent

Please Print: ***Complete all information.***

Name: _____ Birthdate: _____ UR ID: _____

Local Mailing Address _____ Phone #: _____
Street

_____
City State Zip Code

☐ U of R student ☐ Faculty/Staff (Specify Department) _____ ☐ Other: _____

URMC employees must register vaccination in FluSource and send OEM a copy of this form.

INSURANCE INFORMATION: (mark one box)

☐ UR Student Health Insurance (Aetna) ☐ Aetna ☐ BCBS/Excellus ☐ MVP ☐ Other (specify) _____

Please include copy of insurance card

Insurance ID # or Contract #: _____

Subscriber: _____ **Subscriber Date of Birth:** _____

PLEASE ANSWER THE FOLLOWING QUESTIONS: If you respond **"YES"** to any of the following, you **must** consult with a health care provider before receiving flu vaccine. Vaccination may not be safe.	**YES**	**NO**
• **Are you younger than 18 years of age today?** (If <18, you may get flu vaccination but need parental consent.)		
• **Are you allergic to eggs? (**Most can receive this vaccine safely. Have reviewed for approval.)		
• **Have you ever been diagnosed with Guillain-Barre syndrome or a bleeding disorder?**		
• **Are you currently ill with a fever ≥ 101° F**		
• **Do you have a history of severe allergy to a previous dose of influenza vaccine?**		
• **Are you currently or possibly pregnant? (See 2, below)**		

1. Influenza (flu) vaccine may prevent or lessen the severity of influenza disease and is recommended for everyone over 6 months of age.
2. Women who will be pregnant during the influenza season should be vaccinated during any trimester. Those who are pregnant should receive thimerosal-free vaccine. This vaccine is thimerosal-free.
3. Most people have no side effects. When they occur, the most common are local pain or redness, low-grade fever, muscle aches, and/or a tired feeling for one or two days.
4. Annual vaccination is important since the vaccine composition changes to address the changing nature of flu viruses.

If your insurance plan does not cover the flu vaccine, we will bill the cost to your student billing statement or to you directly.

I have read this form completely and have had the opportunity to ask questions. I believe I understand the benefits and risks of influenza vaccine and request that it be given to me. I will advise my primary healthcare provider of my vaccination. I understand that if I have any adverse reaction or have a question about this vaccination, I will call UHS @ 585-275-2662.

PATIENT SIGNATURE: _____ Date _____

For Vaccinator Use Only:

Flu vaccine 0.5 ml IM given by _____, RN Date _____

Site: ☐ Rt Deltoid ☐ Lt Deltoid Mfg: GlaxoSmithKline Lot# N9A39 Exp. Date 6/30/2021

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