

For UHS use only

**INACTIVATED INFLUENZA VACCINATION CONSENT FOR 2019-20, Quadrivalent**

**Please Print: Complete all information.**

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ UR ID: \_\_\_\_\_

Local Mailing Address \_\_\_\_\_ Street Phone #: \_\_\_\_\_

\_\_\_\_\_ 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 <b>must</b> consult with a health care provider before receiving flu vaccine. Vaccination may not be safe.	YES	NO
• <b>Are you younger than 18 years of age today?</b> (If <18, you may get flu vaccination but need parental consent.)		
• <b>Are you allergic to eggs?</b> (Most can receive this vaccine safely. Have reviewed for approval.)		
• <b>Have you ever been diagnosed with Guillain-Barre syndrome or a bleeding disorder?</b>		
• <b>Are you currently ill with a fever <math>\geq 101^{\circ}</math> F</b>		
• <b>Do you have a history of severe allergy to a previous dose of influenza vaccine?</b>		
• <b>Are you currently or possibly pregnant? (See 2, below)</b>		

- Influenza (flu) vaccine may prevent or lessen the severity of influenza disease and is recommended for everyone over 6 months of age.
- 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.
- 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.
- Annual vaccination is important since the vaccine composition changes to address the changing nature of flu viruses.

<b>Flulaval Quadrivalent Vaccine Virus Strains for 2019-20</b>	1. A/Brisbane/02/2018 (H1N1)	3. B/(Colorado/06/2017
	2. A/Kansas/14/2017 (H3N2)	4. B/Phuket/3073/2013

**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 \_\_\_\_\_

<b>For Vaccinator Use Only:</b>	
Flu vaccine 0.5 ml IM given by _____, RN	Date _____
Site: <input type="checkbox"/> Rt Deltoid <input type="checkbox"/> Lt Deltoid Mfg: GlaxoSmithKline Lot# E975Y	Exp. Date <u>6/25/2020</u>

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