University of Rochester | University Health Service
INACTIVATED INFLUENZA VACCINATION CONSENT FORM 2025 - 2026

For UHS use only

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

Legal First Name: _____ Last Name: _____

Birthdate: _____ UR ID: _____ Cell Phone #: _____

Local Mailing Address: 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 Aetna Student Health Insurance Plan (you do not need to enter your subscriber info or include a copy of your insurance card)

☐ Aetna ☐ BCBS/Excellus ☐ MVP ☐ Other (specify) _____

Insurance ID # or Contract #: _____ **Please include copy of insurance card**

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 under the age of 18? (If under age 18, your parent or guardian needs to sign this form.)		
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. Annual vaccination is important since the vaccine composition changes to address the changing nature of flu viruses.
4. 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.

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.

SIGNATURE: _____ Date: _____

PARENT/GUARDIAN SIGNATURE: _____ Date: _____

If under age 18, your parent or guardian must sign this form. Bring the signed form when you come to receive flu vaccine.

For Vaccinator Use Only:				
☐ Flucelvax Trivalent Mfg: Seqirus Exp: 6/10/2026	Lot # 407006	☐ Right Deltoid	Flu vaccine 0.5 ml IM given by	
☐ Fluad Adjuvanted Mfg: Seqirus Exp Date: 5/13/2026	Lot # 407257	☐ Left Deltoid	Date:	**For UHS use only**