Bloomington Hospital

Patient Identification Area

2020-2021 FLU VACCINE CONSENT

PLEASE PRINT

Last Name: _____ First Name: _____ M.I.: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Birth Date: _____ Age: _____ Gender: ☐ Male ☐ Female

Primary Care Provider: _____

Did you receive the Flu vaccine last year? ☐ Yes ☐ No

Please answer the following questions:

1.	Does the person to be vaccinated have an allergy to Thimerosal, eggs, or other vaccine components?	☐ Yes ☐ No
2.	Is the person to be vaccinated sick today?	☐ Yes ☐ No
3.	Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐ Yes ☐ No
4.	Has the person to be vaccinated received other vaccines in the past month?	☐ Yes ☐ No
5.	Has the person to be vaccinated ever had Guillian-Barre syndrome or any other neurological diseases?	☐ Yes ☐ No

I have received, read and understood the contents of the CDC Vaccine Information Sheet (VIS) titled: *Influenza Vaccine, Inactivated, What You Need To Know (08/15/2019)*. I acknowledge I have received/reviewed the Indiana University Health Bloomington Hospital HIPAA Notice of Privacy Practices. I have been given the opportunity to ask questions about the flu shot and the procedure. I understand the possible side effects. I understand that NO guarantees have been made about the results of the inoculation. I request that I be given a flu shot.

Signature:	Date:

FOR CLINIC USE ONLY

Date	Manufacturer	Lot #	Exp. Date	Dosage/Route/Site	Administered By
	Seqirus Fluciuvax	283851	06/30/21	☐ 0.5 ml IM ☐ Deltoid L or R ☐ 0.25 ml IM ☐ AL Thigh L or R	