

Consent Form: 2017-2018 QUADRIVALENT INACTIVATED INFLUENZA VACCINE

A/Michigan/45/2015 (H1N1) pdm09
 A/Hong Kong/4801/2014 (H3N2)
 B/Brisbane/60/2008-like (B/Victoria lineage)
 B/Phuket/3073/2013-like (B/Yamagata lineage)

***Serious egg allergy is no longer a reason for declination as an egg free vaccine will be made available
 (If you can eat eggs, you can get this vaccine)***

(This product does not contain preservatives or Thimerosal. The prefilled syringes are not made with natural latex rubber.)

(THIS IS NOT A LIVE VIRUS VACCINE SO IT CANNOT CAUSE THE FLU)

YES NO

Questionnaire

- | | | |
|--------------------------|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Have you ever had a severe allergic reaction (e.g. anaphylaxis) after a previous vaccine dose or to a vaccine component, including egg protein? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Can you eat eggs or products containing eggs? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Do you have a history of Guillain-Barré syndrome within 6 weeks after a previous Influenza vaccination? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Do you currently have a fever? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Is this your first time receiving the Influenza vaccine? |
| <input type="checkbox"/> | | 6. I Consent to receive the Influenza vaccine. I authorize the designated hospital staff to administer the vaccine. |

Print Name Legibly And Complete ALL Of The Following:

Last Name <small>(As It Appears In Oracle)</small>	First Name <small>(As It Appears In Oracle)</small>	MI	Full Signature
OR			
Blazer ID	SSN <small>(Non-UAB Employee Only)</small>	Job Title	Department Unit
Manufacturer/Lot # /Exp. Date	<input type="checkbox"/> Right Deltoid <input type="checkbox"/> Left Deltoid		<input type="checkbox"/> VIS Given
	Site		
	Signature of Employee Health RN/ Person Administering Vaccine		Today's Date

****Please Complete the Information on the Back of This Page****



Please Check the Box(s) That Apply:

- HOSPITAL EMPLOYEE (Employee on Hospital/ Facility Payroll)**
Includes GME Residents, Fellows, LLC and Health System employees working in the hospital.
 SRC PSYCH

- LICENSED INDEPENDENT PRACTITIONERS (Non-Hospital employees)**
Includes Attendings, Post-Doc. Fellows, Advanced Practice Nurses, SAs and PAs.
 SRC PSYCH

- ADULT STUDENTS/ VOLUNTEERS (18+)/ TRAINEES**
Includes unpaid HCP, Board Members, Observers and Clergy.

- Medical Student Nursing Student Volunteer
 Dental Student Pharmacy Student Trainees
 Student from Non-UAB
Institution (Please Indicate) _____ Other (Please Indicate) _____

- UAHSF (NOT Physicians/ Post-Doc. Fellows/ Advanced Practice Nurses/ SAs, PA's) (NON-TKC)**

- TKC (UAHSF) TKC (LLC)

- HEALTH SYSTEM (Non-Hospital)**

- CONTRACT PERSONNEL**

- Registry/ Agency Nurses (NOT Advanced Practice Nurses)
 Contract Environmental Service Workers
 Contract Maintenance Workers

- OTHER CATEGORIES NOT LISTED: Please Indicate: _____**

*****Thank you for taking the time to complete the entire form. Your name and personal identification will be kept confidential but compliance numbers will be transmitted to the National Healthcare Safety Network (NHSN) and Health and Human Services (HHS as mandated). *****