UAB Medicine
Employee Health Services
Seasonal Influenza Vaccine Consent/Attestation 2020-2021

FILL OUT ALL SECTIONS COMPLETELY-Data is required for CMS influenza vaccination reporting for all staff

Date: _____ **Print *Legal* Name:** _____
FIRST M.I. LAST

Blazer ID *OR* Last 4 SS#: _____ **Date of Birth:** _____

Department: _____ **Supervisor:** _____

Your Contact #: _____ **E-mail Address:** _____

☐ **I am receiving a flu vaccine today – complete the Vaccination Health Screening Questionnaire**

Please Circle Your Response:

1. Have you ever had a severe allergic reaction (e.g. anaphylaxis) after a vaccine or to a vaccine containing egg protein?	Yes	No
2. Have you had a severe allergic reaction to eating eggs?	Yes	No
3. Do you have a history of Guillian-Barré syndrome within 6 weeks after a previous influenza vaccine?	Yes	No
4. Do you currently have a fever?	Yes	No
5. Is this your first time receiving an influenza vaccine?	Yes	No
6. I consent to receive the influenza vaccine. I authorize the designated hospital staff to administer the vaccine.	Yes	

I hereby certify that the above history is true and complete to the best of my knowledge. A serious egg allergy is no longer a reason for declination as an **egg free** vaccine is available.

This vaccine is the most up to date vaccine available.

☐ **I have read the above and the Vaccine Information Statement 2020-2021 was made available to me.**

Employee Signature: _____

For Office Use Only

Injection Site: **Deltoid: Right Left Other site:**	**Vaccine sticker:** ***If Sticker Unavailable:***		
Administered by:	**Lot Number:**	**Expiration date:**	**Vaccine Manufacturer:**

☐ Badge Scanned Into System	☐ TKC Flu Clinic ☐ Gardendale Flu Clinic ☐ Highlands Flu Clinic ☐ Hoover Flu Clinic