Influenza Vaccine Consent Form

Last Name: _____ First Name: _____

Address: _____ City: _____ Phone: _____

Date of Birth: Year_____ Month_____ Day_____ Age: _____

Risk Group (optional question): ☐ 65 Years and Older ☐ Healthcare Worker ☐ Medical Condition

---

Please answer the following questions:

1.	Are you feeling well today?	☐ Yes	☐ No
2.	Have you received a flu shot before?	☐ Yes	☐ No
3.	Have you ever had a reaction to any previous vaccine or injection?	☐ Yes	☐ No
4.	Are you under 19 years of age and undergoing treatment with ASA (acetylsalicylic acid) for long periods?	☐ Yes	☐ No
5.	Are you allergic to eggs, chicken, thimerosal/formaldehyde (preservative).	☐ Yes	☐ No
6.	Are you allergic to Kanamycin or Neomycin (antibiotic)?	☐ Yes	☐ No
7.	Have you ever been diagnosed with Guillain-Barré Syndrome?	☐ Yes	☐ No

Acknowledgement and Waiver

I have read the information about the influenza vaccine and had the chance to ask questions which were answered to my satisfaction. I consent to receiving the influenza vaccine.
I understand that I am to wait under observation at the clinic for the instructed time after the vaccine is given.

Signature: _____ Parent/guardian: _____
(if applicable)

Date of Signature: _____

For Nurse's Use Only:

Vaccine:	**Lot#:** **Exp. Date:** **Lot#:** **Exp. Date:**	Date: _____
Dosage ☐ **0.5mL IM** ☐ **0.7 mL IM High Dose Fluzone (65+)**		Time: _____
Deltoid: ☐ **Right** ☐ **Left**		Site: _____
Anterolateral Thigh**:** ☐ **Right** ☐ **Left**		
Administered by:	as per current Medical Directive Administration of Vaccines	

Student Health Services
J.T. Powell Building, 168 Reynolds Walk
University of Guelph
50 Stone Road East
Guelph, Ontario N1G 2W1

519-824-4120 ext. 52131
wellness.uoguelph.ca/health

STUDENT WELLNESS
Live well. Achieve well.