**Influenza Vaccine Administration Record Informed Consent for Campbell University Students, Employees and Dependents**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employee \_\_\_ Dependent \_\_\_ Student\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Medical Practice \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_Zip \_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I currently do not have a primary care medical provider \_\_\_\_\_\_\_\_\_ \*PCP Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following questions will help us determine if there is any reason we should not give you a vaccination today.

**YES NO Don’t Know**

1. Are you sick today? □ □ □

2. Do you have any allergies to medications, foods (e.g. eggs), latex, or a vaccine component □ □ □
(e.g, gelatin, neomycin, polymyxin, yeast, thimerosal, etc)?

3. Have you ever had a serious reaction (including fainting) after receiving any vaccine? □ □ □

4. Have you had a seizure, or brain or other nervous system problem, or Guillian Barre? □ □ □

5. Has any physician or other healthcare professional ever cautioned or warned you about receiving □ □ □
certain vaccines outside of a physician’s office or hospital?

I hereby give my consent for the Campbell University, Inc. health care provider to administer the specified vaccine. I understand the risks and benefits of receiving the each vaccine and have received, read, and/or had explained to me the Vaccine Information Statement. I have had the opportunity to ask questions, which were answered to my satisfaction. I have been advised to remain at the vaccination location site for approximately 15 minutes after administration for observation and to report any adverse events immediately to the administering/supervising pharmacist. I authorize Campbell University, Inc. to release medical information to my primary care physician.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Pharmacist/PA/DO Completion ONLY**:

RPh/PA-C/DO/MD Name :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RPh/PA-C/DO/MD Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Certified Student Immunizer Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Immunizer Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- | --- | --- | --- |
| Vaccine | Lot # | Exp. Date | Manufacturer  | Dosage | Site | VIS Date | Date PNL Sent |
| Inactivated Influenza  | UJ269AB | 6/30/2020 | Sanofi | 0.5mL | L/R Deltoid IM | 08/15/2019 |  |