MEDICINE | University Health Services

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2024 – 2025 INFLUENZA VACCINE CONSENT FORM

STUDENT ____ FACULTY/STAFF ____

Name ____________________________________ Banner ID ___________________________

Address ____

Date of Birth ______________________________ Phone ______________________________

Please circle Yes or No for all the following questions:

Do you have an egg allergy?	Yes	No
Do you have a history of Guillain-Barré syndrome?	Yes	No
Have you ever had a severe reaction after a dose of influenza vaccine?	Yes	No

By signing this form, I attest that I have reviewed the Influenza Vaccine Information Statement (VIS) and have had an opportunity to ask questions. I understand the benefits and risks of the influenza vaccination as described. I request that the vaccine be given to me.

Signature ____ Date __________________________

FACULTY / STAFF ONLY – Please complete this section or attach a copy of both sides of your insurance card. Without this information, the cost of the vaccine and administration will be billed to your bursar account.

Insurance Company (Circle one)

Blue Cross Health Choice United Aetna Cigna Other ________________

Identification Number ____________________________ Group Number ___________________

UHS STAFF USE ONLY – Manf: Seqirus Lot # AW1614C Exp: 5/31/2025

0.5 ml IM L / R Deltoid Administered by: ____________________________________