STUDENT ___ FACULTY/STAFF ___

UNIVERSITY HEALTH SERVICES

2023-24 INFLUENZA VACCINE CONSENT FORM

Name (please print) **CWID**

Address

Date of Birth **Daytime Phone Number**

You should not receive this vaccine if you: Do you have an egg allergy? Yes No

- Have ever had Guillain-Barré syndrome
- Had a severe reaction after a dose of influenza vaccine

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

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

Insurance Information

Identification Number:_____ Group Number:_____

Company: (please circle)

Blue Cross Healthchoice United Aetna Cigna Other_____

UHS STAFF USE ONLY:

Date:_____Time:_____
0.5ml IM L R Deltoid
Manf: Seqirus Lot# AU1056A
Afluria 2023-2024 Quad Exp: 5/31/2024

Date:_____Time:_____
0.5ml IM L R Deltoid
Manf: Seqirus Lot#
Afluria 2023-2024 Quad Exp: