



2025 – 2026 INFLUENZA VACCINE CONSENT FORM

STUDENT _____

FACULTY/STAFF _____

Name _____ Banner ID _____

Address _____

City

State

Zip

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 _____

STUDENTS – Flu vaccines are provided free of charge to all currently enrolled OSU students.

FACULTY & STAFF – Please complete this section or attach a copy of both sides of your insurance card. Without health insurance 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 – Date _____ Time _____

Manf: Afluria Lot # AX4603C OR AX4605A Exp: 5-31-26

0.5 ml IM L / R Deltoid Administered by _____