HEALTHTRUST
Workforce Solutions

Seasonal Influenza Vaccination Consent Form

I have read or have had explained to me the information about influenza and influenza vaccine. I have had an opportunity to discuss the benefits and risks of influenza vaccine with a healthcare provider of my choice. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of influenza vaccine and request that the vaccine be given to me.

This form can be completed by a Healthcare Provider providing you with the vaccination or you may upload the documentation received when obtaining the vaccination. Flu Vaccination documentation must include Lot Number and Location of Vaccination.

Candidate Full Name:

Signature: Date:

Is the person receiving the vaccine pregnant? Per the CDC, influenza vaccine can be administered at any time during pregnancy. Live attenuated influenza vaccine (i.e., FluMist) should not be used during pregnancy.

☐ Yes ☐ No

Does the person receiving the vaccine have a history of Guillain-Barre syndrome or a persistent neurological illness?

☐ Yes ☐ No

Is the person receiving the vaccine allergic to Thimerosal (preservative found in contact lens solution), any vaccine ingredient, or latex?

☐ Yes ☐ No

DO NOT WRITE IN THIS SPACE - NURSE USE ONLY

Lot Number* : _____ **Expiration Date*:**_____

Vaccine manufacturer*:

☐ Sanofi Pasteur
☐ GlaxoSmithKline (GSK)
☐ Seqirus
☐ AstraZeneca

Vaccine Product*:

☐ Fluzone Trivalent Multi-dose Vial
☐ Fluzone Trivalent Pre-filled Syringe
☐ Fluzone High-Dose Trivalent Pre-filled Syringe
☐ Flublok Trivalent Pre-filled Syringe
☐ Fluarix Trivalent Pre-filled Syringe
☐ FluLaval Trivalent Pre-filled Syringe
☐ Flucelvax Trivalent Pre-filled Syringe
☐ Flucelvax Trivalent Multi-dose Vial
☐ Afluria Trivalent Pre-filled Syringe
☐ Afluria Trivalent Multi-dose Vial
☐ Fluad Trivalent Adjuvanted Pre-filled Syringe
☐ FluMist Intranasal

Location where vaccine was administered*:

☐ HCA Hospital ☐ HCA CareNow facility ☐ HCA Physician Practice ☐ None of the above

Vaccine location*:

☐ Left deltoid ☐ Right deltoid

Signature of person completing form **Date** **Time**

***Required**