Beth Israel Lahey Health
Mount Auburn Hospital

SEASONAL INFLUENZA IMMUNIZATION CONSENT FORM

My signature below indicates that I have had an opportunity to read the Seasonal Influenza Vaccine Information Sheet provided to me by Mount Auburn Hospital and have had all my questions answered satisfactorily. My signature indicates that I understand the questions I answered below, as well as the potential risks, and I consent to receive the vaccine.

PLEASE PRINT CLEARLY

Company name: _____

LEGAL First Name: _____ **LEGAL Last Name:** _____

Date of Birth (mm/dd/yyyy): _____ **Gender:** _____ **Phone #:** _____

Home Street Address: _____

City/Town: _____ **State:** _____ **Zip:** _____

INFLUENZA VACCINATION SCREENING:

1. Are you allergic to eggs or egg products? □ Yes □ No
2. Have you ever had a serious reaction to the flu vaccine? □ Yes □ No
3. Are you currently ill or do you have a fever? □ Yes □ No
4. Have you ever had Guillain-Barre Syndrome (GBS)? □ Yes □ No
5. Are you over the age of 65? □ Yes □ No
6. Do you have an allergy to Thimerosal □ Yes □ No

Signature: _____ **Date:** _____ / _____ / _____

NURSE USE ONLY BELOW:

Manuf/vaccine: Seqirus Afluria NDC #: (**circle**) 33332-320-01 (SDS) 33332-421-10 (MDV) VIS Pub date: 8/6/21

Lot # (exp 6/30/22): (**circle**) P100360866 P100367895 P100367896 P100363800 (MDV)

Injection Site: (**circle**) LEFT RIGHT Deltoid 0.5mL IM Date administered: _____/_____/ 2021

Clinician: (**circle**)
Robin Busiek, RN Faith Manning, RN Caroline Noone, RN
Kelly Reuell, NP Elizabeth Zobel, RN Karolyn LeBlanc, RN
Alison O'Neil, RN Other: _____