PALOMAR HEALTH
Corporate Health Services

Seasonal Influenza Vaccination CONSENT

Name (print):_____ Employee ID #:_____

In the past year, have you experienced any of the following symptoms **NOT** associated with a specific illness (i.e. cold or flu) and lasting more than 3 weeks?

1. Is this the first flu vaccination you have ever received? ☐ Yes ☐ No
2. Have you ever had an allergic or serious reaction to the following: ☐ Yes ☐ No
   Flu vaccine, chicken eggs, or chicken products, Thimerosal, or have you had Guillain-Barre Syndrome (GBS)?
3. Are you ill today? ☐ Yes ☐ No
4. Do you take blood thinners such as Aspirin, Clopidogrel (Plavix), Dipyridamole (Aggrenox), or Coumadin (Warfarin) on a daily basis? ☐ Yes ☐ No
5. Are you under 18 years of age? ☐ Yes ☐ No
   If you are under 18 years of age parental consent is required.
6. Are you pregnant? ☐ Yes ☐ No

Date of Birth:_____ Telephone: _____

I have received the CDC Influenza Vaccine Information Statement (VIS). By signing below I attest to understanding the VIS and consent to receive influenza vaccine.

Signature: _____ Date: _____

For Vaccinator Use Only:

Manufacturer: _____ Lot #:_____ Exp. Date:_____

Route: IM **Site:** ☐ R Deltoid ☐ L Deltoid

☐ VIS: Inactivated Influenza Vaccine

Signature: _____ Date: _____