



Saint Alphonsus

Corporate Health Services

Administered by:
Date Administered :
Route: <i>Check IM or Intranasal after administering vaccinations.</i>
IM _____ R _____ L _____ Vaccine: Influenza Virus Vaccine Dose: 0.50 ml
Intranasal _____ Vaccine: Intranasal LAIV Dose: 0.2 ml (0.1 ml in each nostril)
Lot #:
Expiration Date:

2010-2011 Corporate Vaccination Consent & Release

1. Decide if you would like the 'flu shot' or the Intranasal Flu Mist and circle your choice below – review the Vaccine Information Sheets for details on both vaccines
2. Answer the questions below
3. Take this consent form to the nurse and review your answers

Name: _____

Date of Birth: _____ Age: _____ Sex: M _____ F _____

VACCINE PREFERENCE (circle one)

FLU SHOT

INTRANASAL FLU MIST
(not eligible for people over 50 years of age)

CONSENT:

I hereby acknowledge that I have received and read the information sheet corresponding to my vaccination choice: “Inactivated Influenza Vaccine – What You Need To Know 2010-2011” (VIS date: 08/10/10) for the inactivated flu vaccination shot or "Live Intranasal Influenza Vaccine – What You Need to Know 2010-2011 (VIS date: 08/10/2010). I wish to receive, and I have had an opportunity to ask questions.

Please check Yes or No for the following questions	Yes	No
1. Do you have a severe egg allergy?		
2. Are you allergic to the preservative Thimerosal?		
3. Have you ever had a severe adverse reaction to a flu vaccine –either the shot or the intranasal mist?		
4. Are you sick today?		
5. Have you ever had Guillain-Barre Syndrome?		
6. Do you have thrombocytopenia or any blood disorder that would prohibit a shot in your muscle?		
7. Women: Are you pregnant or could you become pregnant in the next month?		
If requesting Flu Mist – please also answer the following questions		
1. Are you 50 years of age or older?		
2. Do you have a long term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorders?		
3. Do you have a weakened immune system because of disease that affects the immune system, long-term treatment with drugs such as steroids, or cancer treatment with x-rays or drugs?		
4. Have you received any other vaccinations in the past 4 weeks?		

* "Yes" answers may disqualify you from receiving the flu shot or the intranasal mist.

I understand the risks of receiving the influenza vaccine, and I acknowledge that I have freely chosen to assume such risks by signing this release and receiving this vaccine. Furthermore, I hereby release and forever discharge, for myself, my heirs, executors, administrators, and assignees, my employer, its subsidiaries and their directors, officers, employees, agents, representatives, successors and assigns, as well as the independent professional physicians and nursing staff retained by my employer in connection with the administration of the flu vaccine, from any and all claims, demands, actions, and causes of action which may result or arise from my receipt of this vaccine.

Signature: _____

Date: _____