Stanford | Environmental Health & Safety
Occupational Health Center

2021-2022 Seasonal Flu Vaccination Consent

Last Name	First Name	MI	SLAC ID# (6 digits) OR SU/Student ID# (8-9 digits)	Date of Birth (mm/dd/yyyy)

☐ I have an SHC/LPCH or Blood Center Badge ☐ I am a physician in the School of Medicine

Please check the box which best describes you:

Primary University Affiliate	Spouse/Domestic Partner (*= $32 charge)
☐ Stanford University Faculty / Staff / Employee	☐ of Stanford University Faculty / Staff / Employee*
☐ SLAC Employee	☐ of SLAC Employee*
☐ Part-time Casual or Temporary Employee	☐ of Part-time Casual or Temporary Employee*
☐ Postdoctoral Scholar / Fellow	☐ of Postdoctoral Scholar / Fellow*
☐ Undergraduate Student	☐ of Undergraduate Student (no charge)
☐ Graduate Student	☐ of Graduate Student (no charge)
☐ Medical Student	☐ of Medical Student (no charge)
☐ Retiree	☐ of Retiree*

Under which Stanford health insurance plan are you covered?

☐ Stanford Healthcare Alliance	☐ Kaiser Permanente	☐ Aetna EPO
☐ Cardinal Care	☐ Blue Shield / High Deductible	☐ Other / None

Please mark YES or NO for each answer	YES	NO
1. Are you allergic to eggs?		
2. Have you had a serious (life-threatening) reaction to influenza vaccine in the past?		
3. Have you had a serious (life-threatening) reaction to hydrocortisone[1] or gentamicin[1 (antibiotic)]?		
4. Do you have a history of Guillain-Barré Syndrome (causing temporary paralysis)?		
5. Are you ill today with a moderate to severe illness (with fever)?		

If you answered "Yes" to questions 1-4, vaccine may be contraindicated. Please discuss with our staff, or speak to your personal physician.
If you answered "Yes" to question 5, you should postpone vaccination until you are feeling better.

Patient Consent

I have read the Influenza Vaccine Information Sheet (VIS). I have had an opportunity to ask questions which were answered to my satisfaction. I believe I understand the benefits and risk of the influenza vaccine and request that it be given to me.

→ _____ _____

Signature of person receiving the vaccine **Today's Date**

---------- FOR ADMINISTRATIVE USE ONLY ----------

	VIS Date	Date of Vaccination	Dose and Route 0.5 ml IM		Vaccine Manufacturer	Lot Number	Expiration Date
Seasonal Influenza Vaccine	8/6/2021		☐ Left Deltoid	☐ Right Deltoid	☐ Flucelvax (Seqirus)	308446	6/26/2022
					☐ Fluzone HD (Sanofi)		
					☐ Fluad HD Quad (Sequirus)		
					☐ Fluarix[1] Quad (GSK)	5X7J5	6/30/2022

Vaccine Administrator (circle one)

MD RN NP PA MA MS PAS

S.Aguilar N.Iniguez M.Martinez C.Labson N.Molina-Ortega M.Rojas-Santoyo R.Wittman R.Puri M.Moharir C.McNamara P.Fast N.Stoll T.Wright D.Hong C.Song T.Cerone M.Curry S.Rohlfes **Other:** _____

Signature:_____

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