UHealth
UNIVERSITY OF MIAMI HEALTH SYSTEM

UNIVERSITY OF MIAMI
MILLER SCHOOL
of MEDICINE

PLEASE PRINT! Seasonal Flu Vaccine Consent Form

Name:(Last) (First) UMID#

Date of Birth (e.g., 1/2/1972) Job Title or Position:

Department Name: Work Phone:

Work Address: Building Name: Room#:

Work Location: ☐Medical ☐Gables ☐RSMAS ☐UMHC/SCCC ☐BPEI ☐UMH ☐Other_____

Job Class: ☐MD ☐Med Student ☐PhD ☐ARNP ☐RN ☐PA ☐Other UM Student ☐Other: _____

Fluzone is latex and thimerosal free.

You should not receive Influenza vaccines if:

You have any severe, life-threatening allergies; if you ever had a life-threatening allergic reaction after a dose of flu vaccine, or have a severe allergy to any part of this vaccine (most, but not all, types of flu vaccine contain a small amount of egg protein, however, egg free vaccine is available); if you ever had Guillain-Barré Syndrome (also called GBS); or if you are not feeling well. It is usually okay to get the flu vaccine when you have a mild illness, but you might be asked to come back when you feel better.

Possible reactions to the Flu vaccine:

Mild: Soreness or redness at the site of the shot; fever; body aches.

Severe: Acute allergic reaction – high fever; confusion; difficulty breathing; hives; rapid heartbeat – would occur within a few minutes of the vaccine. Guillain-Barre Syndrome – progressive muscle weakness and paralysis –may occur within days to weeks after the Flu vaccine.

1. Do you work with patients or work in an area where patients are seen?	☐ Yes	☐ No
2. Do you feel sick or have a high fever today?	☐ Yes	☐ No
3. Do you have severe allergy to eggs? **(If YES, *give Egg Free Vaccine*)**	☐ Yes	☐ No
4. Have you ever had a severe reaction or anaphylaxis to a previous flu vaccine?	☐ Yes	☐ No
5. Have you ever had Guillain-Barre Syndrome (a severe paralyzing illness)?	☐ Yes	☐ No
6. Are you allergic to Latex?	☐ Yes	☐ No

7. ***List any other allergies:***

If you have had recent chemotherapy, radiation therapy, or steroids, these conditions may decrease the effectiveness of the vaccine. However, flu vaccination is still recommended. Flu vaccination **is recommended** for any woman who will be or is **pregnant or breastfeeding** during the influenza season. Vaccination can be given in any trimester.

Consent

I have read the Influenza vaccine information sheet dated 8/15/2019. I have been provided an opportunity to ask questions about influenza and its treatment. I understand the risks and benefits of the vaccination. I understand that the vaccination that I am about to receive is a single shot and it will not be fully effective for approximately two weeks. However, as with all vaccines, there is no guarantee that I will become immune or that I will not experience side effects. I understand that I should not receive the flu vaccine if I have ever had a life-threatening allergic reaction to a previous influenza vaccine, or have a severe allergy to any part of this vaccine or if I have ever had Guillain-Barré Syndrome (a severe paralyzing illness, also called GBS). **I hereby give consent to receive the influenza vaccine.**

Signature of Vaccine Recipient:_____ ***Date***:_____

Do not write below this line. OFFICE USE ONLY- PLEASE PRINT

NAME OF YOUR CLINIC (for example, UMH):	Today's Date:
Name of Flu Vaccine: Manufacturer:	Route ☐ Intramuscular 0.5 ML
Lot Number: Expiration Date:	Location: ☐ R Deltoid ☐ L deltoid
***Administered by (CLEARLY PRINT YOUR NAME)*:**	