OSF HealthCare Saint Luke Medical Center
Screening and Consent for Influenza Vaccination – Inactivated

Complete questions 1-5 on this form

Legal Birth Name:	Date of Birth:
Doctor:	School:
Grade:	Teacher:

YES	NO		
☐	☐	1.	Are you allergic to eggs or egg products?
☐	☐	2.	Are you allergic to Thimerosal (a preservative) other than contact lens sensitivity?
☐	☐	3.	Have you ever had Guillian-Barre Syndrome within 6 weeks of taking a flu shot?
☐	☐	4.	Have you ever had a previous adverse reaction to the influenza vaccine?
☐	☐	5.	If the student is less than 8 years old, is this the first dose?

Influenza Vaccination Consent

I have read and understand the Vaccine Information Statement (VIS) published on 8/6/2021.
I have been given an opportunity to ask questions, which were answered to my satisfaction.
I believe that I understand the benefits and risks of taking the flu vaccine, and I request that the vaccine be given to me or to the person named for whom I am authorized to sign.
I verify that I am not allergic to eggs and that I have not had a serious allergic reaction associated with the flu vaccination in the past.

Signature of Parent/Guardian_____

Date_____

FOR OFFICE USE ONLY

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

Site: _____ Dose: 0.5ml 0.25ml Temp_____

Signature:_____Date:_____