ASCENSION

Ascension Illinois Influenza Vaccine Acknowledgement and Consent Form

Recipient Information *(Please Print Clearly)*

Last Name: _____First Name: _____ Age: _____ Date of Birth: _____

Home Address: _____City: _____State: _____ Zip Code: _____

Phone Number: _____ Gender: ❑ Male ❑ Female ❑ Other Preferred Language: _____

Race: ❑Hispanic or Latino ❑non-Hispanic or Latino ❑unknown ❑prefer not to say

Ethnicity: ❑American Indian/Alaska Native ❑Asian ❑Black/African American ❑Native Hawaiian/Pacific Islander ❑White

	Yes	No
1. Are you 18 years of age or older?		
2. Have you ever received the flu vaccine?		
3. If yes, did you have a life threatening reaction? Explain Reaction: _____		
4. Are you allergic to eggs or egg products? If no, skip to question 5.		
If yes, have you received the egg-free vaccine?		
Did you have any reaction to the egg-free vaccine?		
5. Have you had a temperature of 101F or over, respiratory infection, nausea, vomiting or diarrhea within the last 24 hours?		
6. Have you ever been paralyzed by Guillain-Barré Syndrome?		
7. Have you received any vaccine in the past 30 days?		
8. Are you allergic to or do you have a known hypersensitivity to neomycin sulfate or polymyxin B?		
9. Are you on anticoagulant therapy?		
10. Females Only: Are you pregnant?		

*An allergic reaction includes a severe allergic reaction (e.g. anaphylaxis) that required treatment with epinephrine or EpiPen or that caused you to go to the hospital. It would also include an allergic reaction that occurred within four (4) hours that caused hives, swelling, or respiratory distress, including wheezing.

I hereby give my consent to Ascension Illinois, to administer the Influenza Vaccine and I agree with the following statements:

- I understand the benefits and risks of the influenza vaccine.
- I have received and reviewed a copy of the Influenza Vaccine Statement (VIS).
- I have had a chance to ask questions and these have been answered to my satisfaction.
- I may experience mild reactions including soreness at the injection site, aches, and mild fever.
- If I begin to have wheezing or breathing problems, hives, or severe rash I am to immediately report to the nearest emergency room for treatment of a possible severe allergic reaction and follow up with my primary care physician.

_____

Signature of person to receive vaccine or person authorized to make request Date

For Office Use Only

Clinic Site: _____ Ascension Illinois Location: ❑AHF ❑AM ❑AR ❑ASJE ❑ASME ❑ASMK

Vaccine Manufacturer Name
Lot# / Expiration Date

Injection Site:
☐ Right Deltoid ☐ Left Deltoid

Inactivated influenza vaccine
Vaccine Information Statement
(VIS) 8/6/2021 given _____ Initials

_____ _____

Signature and title of health professional administering the vaccine Date

Ascension Resurrection, 7435 West Talcott Avenue, Chicago, IL 60631 – Community Health 773-990-5022