

**HIGHLIGHTED AREAS MUST BE COMPLETED**

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| <p><b>UNIVERSITY OF KENTUCKY<br/>UNIVERSITY HEALTH SERVICE<br/>830 South Limestone Street<br/>Lexington, KY 40536-0582</b></p> <p><b>VACCINATION CONSENT<br/>Big Flu Madness 2021-2022</b></p> | <p>Patient Name _____<br/>(FULL LEGAL NAME) – PRINT LEGIBLY</p> <p>Student/Employee ID # _____</p> <p>Date of Birth _____</p> <p>Are you a minor (under the age of 18)? <input type="checkbox"/> yes <input type="checkbox"/> no<br/>If yes, STOP and see a member of registration for an additional parental consent if not present</p> <p><input type="checkbox"/> UK <input type="checkbox"/> Contract/Visiting Scholar</p> |
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**INJECTABLE INFLUENZA VACCINATION – SCREENING QUESTIONNAIRE**

**For adult patients:** The following questions will help us determine if there is any reason we should not give you injectable influenza vaccination today. If you answer “yes” to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your health care provider to explain it.

|   | Yes | No | Don't Know |
|---|-----|----|------------|
| 1. Are you sick today?  |     |    |            |
| 2. Do you have an allergy to eggs or to a component of the vaccine?       |     |    |            |
| 3. Have you ever had a serious reaction to influenza vaccine in the past? |     |    |            |

**Informed Consent for Administration of Vaccines:**

I have received and read (or had explained to me) information about the virus(es) and vaccine(s) indicated above. I have had the opportunity to ask questions, which were answered to my satisfaction. I understand the risks and benefits of the vaccine(s). I also understand that, as with all medical treatment, there is no guarantee that I (or the patient) will become immune or will not experience adverse side effects from the vaccine. I request that it be given to me (or to the patient for whom I am authorized to make this request).

**X**

Signature of person receiving vaccine or person authorized to consent to vaccine \_\_\_\_\_

\_\_\_\_\_ Date

Signature of witness \_\_\_\_\_

\_\_\_\_\_ Date

**For Vaccinator Completion Only:**

| DATE | VACCINE   | DOSE   | SITE        | MFR     | LOT # | EXP. DATE | SIGNATURE |
|------|-----------|--------|-------------|---------|-------|-----------|-----------|
|      | INFLUENZA | 0.5 ml | IM<br>LD RD | GlaxoSK | X4J9R | 6/30/22   |           |