BAPTIST MEMORIAL HEALTH CARE
EMPLOYEE HEALTH SERVICES

SEASONAL INFLUENZA VACCINATION RECORD

Last Name First M.I.	Last 5 Digits Social Security #	Employee ID #	Department/Clinic/School

☐ **Baptist-Paid Employee**	☐ **Baptist-Paid MD/APP**		
☐ Allied Health Professional	☐ Vendor/Contract	☐ Contract MD/ICP/APP	☐ Other (indicate below)
☐ Student	☐ Volunteer	☐ Fellow	

CONSENT FOR SEASONAL INFLUENZA VACCINATION

	YES	NO	N/A
1. **Are you 18 years of age or older?**			
2. Do you have a severe allergy to **eggs or egg products**?			
3. Are you sensitive to **latex?**			
4. Have you fainted or had a life threatening reaction to a previous flu vaccine?			
5. Have you had a severe allergic reaction to **thimerosol** (a substance containing Mercury that is used as an antiseptic and germ killer) or , **neomycin, polymyxin, or gentamicin** (antibiotics)? (May be processed with beta-propiolactone, nonylphenol ethoxylate, sodium taurodeoxycholate, sodium chloride, monobasicsodium phosphate, dibasic sodium phosphate, monobasic potassium phosphate, potassium chloride, calcium chloride, polysorbate 80 & ovalbumin.)			
6. Any illness within the past 3 days or fever greater than 100 F?			
7. Do you have history of Guillain Barre' Syndrome?			

I have been provided with the relevant vaccine information materials produced by the Centers for Disease Control and Prevention (CDC) about the seasonal Influenza vaccine that I wish to have administered to me (the "Vaccine"). I have read and understand the information provided and have had the opportunity to inquire about the Vaccine to my satisfaction. If I am a woman, I understand that the effects of the Vaccine on a developing fetus or a woman's reproductive ability are not fully known. However, the CDC recommends that pregnant women receive the Vaccine due to the higher risk for serious complications from influenza during pregnancy. I understand the risks and benefits associated with the Vaccine, and I also understand the risks associated with vaccines generally. I realize that I might have adverse side effects from the Vaccine which could be serious. I authorize the administration of the Vaccine to me.

Signature____ Date_____________

Vaccination Date	Manufacturer/Lot#/Expiration Date:	Site/Dosage: 0.5ml L____R____Deltoid	Administered By: VIS Date: 08/07/15

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