

# 2022-2023 Consent for Influenza Vaccination

**1** Are you an MNH employee, volunteer or contracted service? Yes  No   
If **YES**, please ask for an **Employee Health Consent Form**. If **NO**, please proceed to Step 2.

**2** Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Legal Sex:  F  M  Nonbinary  Unknown PCP Doctor's Name: \_\_\_\_\_  
Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (Home/Mobile) Email: \_\_\_\_\_

**3**

COVID-19 Screening			Influenza Screening		
Have you had a fever, cough, shortness of breath, loss of taste or smell or any other cold/flu symptoms in the last 24 hours?	Yes	No	Have you received the flu vaccine before?	Yes	No
Have you or a household member been tested, diagnosed, or awaiting COVID-19 test results in the last 14 days?	Yes	No	Have you had a severe reaction to the flu vaccine in the past?	Yes	No
			Do you have a serious allergy to chicken eggs? <i>If yes, please discuss vaccination options with physician or allergist.</i>	Yes	No
			Do you have a history of Guillian-Barre Syndrome (GBS)?	Yes	No
			Are you currently sick with a fever?	Yes	No

**4**

### Participant/Parental Informed Consent Signature

By signing, I have received and agreed to the following:

- Received and read the vaccine information sheet (dated 8/6/21) regarding benefits and risks of receiving the Influenza vaccine;
- Had the opportunity to have questions answered regarding the vaccine;
- Consented to be immunized or have my child immunized;
- Understand that if my child is aged less than 9 years, I should consult my physician to determine if a second dose is indicated.**

I hereby release Mount Nittany Health, its hospitals, physicians, employees, agents, representatives and assigns, including but not limited to the property owner upon which the event takes place, and its respective parent, subsidiary and affiliated companies, from any and all liability that may be associated with my (my child's) receipt of the influenza vaccine.

Signature of person being immunized, or authorized representative:  
X \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
*If under age 18, need parental/guardian consent.* Telephone consent witnessed by: \_\_\_\_\_

**5**

### FOR INTERNAL USE ONLY

Vaccine Manufacturer: Sanofi Pasteur      **Site:** \_\_\_\_\_      **Date:** \_\_\_\_/\_\_\_\_/2022  
Lot# \_\_\_\_\_       Left Arm  
Expiration Date: \_\_\_\_\_       Left Leg       Inactivated Flu Vaccine  
Dose: \_\_\_\_\_       Right Arm       High Dose Flu Vaccine  
 Refused Vaccine       Right Leg       Flublok Vaccine

Rev. 10/13/22 • Version 2      Vaccinator Signature and Credentials: \_\_\_\_\_