MOUNT NITTANY
PHYSICIAN GROUP

2021-2022 Consent for Influenza Vaccination

1

Are you an MNH employee, volunteer or contracted service? Yes O No O

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: O F O M O Nonbinary O 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 symp-toms 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**	Severe reaction to the flu vaccine in the past?	**Yes**	**No**
			Serious allergy to chicken eggs? ***If yes, please discuss vaccination options with physician or allergist.***	**Yes**	**No**
			History of Guillian-Barre Syndrome (GBS)?	**Yes**	**No**
			Currently sick with a fever?	**Yes**	**No**
			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**:

_________/_________/2021

Lot# ______________ O Left Arm

Expiration Date: ______________ O Left Leg O Inactivated Flu Vaccine

Dose: ______________ O Right Arm O High Dose Flu Vaccine

O Refused Vaccine O Right Leg O Flublok Vaccine

Vaccinator Signature and Credentials: ______________________