MOUNT NITTANY PHYSICIAN GROUP

2024-2025 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 Vaccine Screening**		
Have you or a household member been tested, diagnosed, or awaiting COVID-19 or flu test results in the last 14 days?	**Yes**	**No**	Is the person to be vaccinated sick today?	**Yes**	**No**
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**	Does the person to be vaccinated have an allergy to an ingredient of the vaccine?	**Yes**	**No**
			Have you had a severe reaction to the flu vaccine in the past?	**Yes**	**No**
			Has the person to be vaccinated ever felt dizzy or faint before, during or after a shot?	**Yes**	**No**
			Do you have a history of Guillian-Barre Syndrome (GBS)?	**Yes**	**No**
			Is the person to be vaccinated anxious about getting a shot?	**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: _____

FOR INTERNAL USE ONLY

5

Vaccine Manufacturer: Sanofi Pasteur

Lot# _____

Expiration Date: _____

Dose: _____

○Refused Vaccine

Site:

○ Left Arm
○ Left Leg
○ Right Arm
○ Right Leg

Date: _____/_____/2025

○ Inactivated Flu Vaccine
○ High Dose Flu Vaccine
○ Flublok Vaccine

Vaccinator Signature and Credentials: _____