

2025-2026 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	Influenza Vaccine Screening <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 5px;">Is the person to be vaccinated sick today?</td> <td style="text-align: center; padding: 5px;">Yes</td> <td style="text-align: center; padding: 5px;">No</td> </tr> <tr> <td style="padding: 5px;">Does the person to be vaccinated have an allergy to an ingredient of the vaccine?</td> <td style="text-align: center; padding: 5px;">Yes</td> <td style="text-align: center; padding: 5px;">No</td> </tr> <tr> <td style="padding: 5px;">Have you had a severe reaction to the flu vaccine in the past?</td> <td style="text-align: center; padding: 5px;">Yes</td> <td style="text-align: center; padding: 5px;">No</td> </tr> <tr> <td style="padding: 5px;">Has the person to be vaccinated ever felt dizzy or faint before, during or after a shot?</td> <td style="text-align: center; padding: 5px;">Yes</td> <td style="text-align: center; padding: 5px;">No</td> </tr> <tr> <td style="padding: 5px;">Do you have a history of Guillian-Barre Syndrome (GBS)?</td> <td style="text-align: center; padding: 5px;">Yes</td> <td style="text-align: center; padding: 5px;">No</td> </tr> <tr> <td style="padding: 5px;">Is the person to be vaccinated anxious about getting a shot?</td> <td style="text-align: center; padding: 5px;">Yes</td> <td style="text-align: center; padding: 5px;">No</td> </tr> </table>			Is the person to be vaccinated sick today?	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
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4	Participant/Parental Informed Consent Signature By signing, I have received and agreed to the following: - Received and read the vaccine information sheet (dated 01/31/2025) 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: ____/____/____ <i>If under age 18, need parental/guardian consent.</i> Telephone consent witnessed by: _____																				
5	FOR INTERNAL USE ONLY																				
	<table style="width: 100%;"> <tr> <td style="width: 40%;">Vaccine Manufacturer: Sanofi Pasteur</td> <td style="width: 20%;">Site: _____</td> <td style="width: 40%;">Date: ____/____/2025</td> </tr> <tr> <td>Lot# _____</td> <td>☐ Left Arm</td> <td></td> </tr> <tr> <td>Expiration Date: _____</td> <td>☐ Left Leg</td> <td>☐ Inactivated Flu Vaccine</td> </tr> <tr> <td>Dose: _____</td> <td>☐ Right Arm</td> <td>☐ High Dose Flu Vaccine</td> </tr> <tr> <td>☐ Refused Vaccine</td> <td>☐ Right Leg</td> <td></td> </tr> </table>			Vaccine Manufacturer: Sanofi Pasteur	Site: _____	Date: ____/____/2025	Lot# _____	☐ Left Arm		Expiration Date: _____	☐ Left Leg	☐ Inactivated Flu Vaccine	Dose: _____	☐ Right Arm	☐ High Dose Flu Vaccine	☐ Refused Vaccine	☐ Right Leg				
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