

**YORK HOSPITAL**



**(Patient) VACCINE CONSENT AND ADMINISTRATION RECORD  
2011 – 12 [Inactivated] Influenza**

*"I have read, or have had read to me, the information on the sheet about Influenza and the influenza vaccine [VIS Inactivated Influenza Vaccine 2011 – 2012 (07/26/11)]. I have had a chance to ask questions that were answered to my satisfaction. I believe that I understand the benefit and risks of the influenza vaccine and ask that the vaccine be given to me or to the person named below for whom I am authorized to make this request.*

- 1. Do you have a severe allergy to hen's eggs?  Yes  No
- 2. Have you had a previous severe reaction to Influenza vaccine?  Yes  No
- 3. Do you have an allergy to Thimerosal\*?  Yes  No
- 4. Do you have a fever or symptoms of a moderate to severe illness?  Yes  No
- 5. Have you ever had Guillian-Barre' syndrome\*\*?  Yes  No

*\* A mercury-containing preservative used in some vaccines and other products since the 1930's. No harmful effects were reported from thimerosal at doses used in vaccines, except for minor local reactions like redness and swelling at the injection site.*

*\*\* A rare disorder in which the body's immune system attacks part of the peripheral nervous system and causes paralysis.*

**INFORMATION ABOUT PERSON TO RECEIVE THE VACCINE (PLEASE PRINT)**

Name: \_\_\_\_\_ Male/Female  
Last First MI Birth Date Sex

Address: \_\_\_\_\_  
Street City State Zip

Physician Name: \_\_\_\_\_ Medicare ID#: \_\_\_\_\_

Phone #: \_\_\_\_\_ Medicaid ID#: \_\_\_\_\_

What is your primary insurance? \_\_\_\_\_

Other insurance #: \_\_\_\_\_ Name of Insured: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_  
(supplemental)

Relationship to patient: \_\_\_\_\_

**SIGNATURE OF PERSON TO RECEIVE VACCINE, OR PERSON AUTHORIZED TO MAKE THE REQUEST:**

X \_\_\_\_\_ Date: \_\_\_\_\_

**Injection Site:** Deltoid  left  right **Vaccine Lot #** \_\_\_\_\_

**Vaccine Given By:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Patient Sticker here*