Texas Tech University Health Sciences Center
Influenza Vaccine Consent Form
2014-2015

Information about the person to receive vaccine **(Please Print)**

Name: Last First

_____

Department: _____

Direct Patient Contact: *Yes or No*

Circle one: Faculty Staff Student Resident/Fellow

Allergies: _____

Y/N Severe anaphylactic hypersensitivity to eggs
Y/N History of Guillain-Barre Syndrome
Y/N Moderate to severe illness at this time
Y/N History of severe reaction or allergy to vaccine component

Information Statement – ***Please check off the following statements:***

___ I have been given a copy and have read the information sheet
.
___ I have been given a chance to ask questions which were answered to my satisfaction.
___ I believe that I understand the benefits and risks associated with this vaccine, and I request that the vaccine be given to me.

Signature of Person to receive vaccine:

X _____Date _____

(For Nurse to Complete)

Date Vaccine Administered: _____

Vaccine Manufacturer:

Vaccine Lot Number: Expiration date of vaccine:

Site of Injection: Right Deltoid ☐ Left Deltoid ☐

Signature and Title of Vaccine Administrator: X_____