UNIVERSITY OF ILLINOIS SPRINGFIELD
Health Services • BSB 20 • (217) 206-6676 • Fax (217) 206-7779
uishealthservice@uis.edu

Influenza Vaccination
Consent & Administration Form

Place sticker:

Name: ______________________

OR [UIN: ______________________
State Employee SSN* (last 4 digits only): XXX – XX – ________]

DOB ______________________

Age: ________ Email Address: ______________________

Telephone: ______________________

Address: ______________________

Current medications

Please list your current medication. Include prescription medication and over the counter medications/drugs:

Medical history

I am not pregnant or breastfeeding (if yes, LAIV contraindicated, TIV recommended.	☐
I am not allergic to Thimerosal.	☐
I do not have an acute illness or infection.	☐
I am not allergic to egg or latex.	☐
I do not have Guillain-Barre syndrome.	☐

Allergies

Please list any allergies that you may have:

** With respect to your social security number, note the following. The provision of a flu shot is a gratuitous one being made available to you by your employer. These digits, along with the other information on this form, will be used to facilitate prompt payment to the health care provider and in any other manner consistent with HIPAA, state and federal statute and regulations. Information will be kept confidential as required by HIPAA and all other state and federal statutes and regulations.*

The clinic may keep this record in your medical file. They will record what vaccine was given and the date administered, the name of the company that made the vaccine and the lot number, the signature and title of the person who administered the vaccine and the location where the vaccine was given.

"I have read or have had explained to me information provided by Health Services regarding influenza and the influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits as well as the risks of the influenza vaccine, and have given permission to have the vaccine administered to me."

Signature: ______________________ Date: ____/____/____

HEALTH SERVICES USE ONLY

☐ Staff / Faculty ☐ Student ☐ IL State Employee / Retirees ☐ Other: ______________

Payment: ☐ Cash $______ ☐ Check $______ Check # ______ ☐ Bill Student Account ☐ Bill State of IL

Site Location: **UIS** ________ Clinic ________ Satellite

VIS form given: ☐ **Yes** ☐ **No** VIS form date: 08 / 15 / 2019 VIS given by: ______________

Influenza Administration

Has advice been given about the requirements for 1 dose (a full course)? ☐ **Yes** ☐ **No**

Has patient been advised of side effects (inflammation at vaccine site and slight malaise for a day or two)? ☐ **Yes** ☐ **No**

1. Name of vaccine: Seqirus-Influenza Vaccine afluria Quadrivalent ☐ **Lot number:** P100115156 **OR** P100118562 **Expiration date:** 06 / 30 / 2020

Route: ☐ IM Site of vaccination: ☐ RT deltoid ☐ LT deltoid Nurse Signature: ______________ Date: ________

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