OptimaHealth
A Service of Sentara

Influenza Vaccination Consent Form

Completion of this form is required to receive an influenza vaccination offered by Optima Health.
PLEASE WRITE LEGIBLY!

Participant completes **Section 1** **Health Professional** completes **Section 2**

Section 1: Participant completes this section

Name (printed): _____ Phone_____
(Best way to reach you)

Do you have any communication needs that require additional arrangements? Yes___ No___

Health insurance (circle one): *Optima Health Other None* Optima member number **OR** last four of SSN _____

Is this your first influenza vaccination (Flu Shot)? Yes___ No___ When did you receive your last Flu Shot: _____

Do you have any allergies? (Especially: Thimerosal) If yes, please list: _____
_____

*If you answer **"Yes"** to any of the following questions, **GO TO YOUR HEALTH CARE PROVIDER FOR YOUR INFLUENZA VACCINATION (Flu shot).***

Please circle your response.

Do you currently have a moderate fever or severe illness with fever?	**Yes**	**No**
Have you ever had a serious reaction to eggs or egg products?	**Yes**	**No**
Have you ever required medical care because of a reaction to a previous flu vaccination?	**Yes**	**No**
Have you ever been diagnosed with Guillain-Barre syndrome?	**Yes**	**No**
Are you 17 years of age or younger?	**Yes**	**No**

I hereby consent to have an influenza vaccine administered by a Sentara representative. I understand that it is voluntary and that I may withdraw my participation at any time. I hereby waive any claims and release Sentara Healthcare of any and all liabilities arising out of, or associated with this procedure. I understand information provided at this time is not a substitute for the advice, care, diagnosis or treatment of my physician. The confidentiality of all individual reports will be protected. If any Sentara Healthcare team member is directly exposed to my blood, I agree to provide Sentara Healthcare a venous blood sample for lab testing for HIV, Hepatitis B and C and/or any other infectious diseases. I understand that a Sentara Healthcare provider will inform me and the exposed Sentara Healthcare team member of the results of the testing.

Name (signature) _____

Date: _____

Section 2: Health Professional completes this section

Right Deltoid _____ Left Deltoid _____ Dosage: 0.5 ml

Vaccine Manufacturer: GSK Lot # 49LC5 Expiration Date: 06/30/2022

Nurse's Signature: _____ Date: _____

_____ **Patient had a vaccine reaction and was treated in accordance with standing orders in the Medical Management of Vaccine Reactions in Adults Sentara Health and Preventive Services policy.**

Facility or Site Location: _____