Adult Influenza Vaccine Informed Consent and Release Form
UI Health Ambulatory Care Pharmacy Dept- WEST Campus Student clinic 2019
PLEASE PRINT CLEARLY

_____ _____ ❑Female
Print Last Name **Print First Name** **Middle initial** **Birth Date** ❑Male

_____ _____
Address **City** **State** **Zip Code** **Contact Phone #**

1) **I have CAMPUS CARE insurance ❑YES, UIN #_____ ❑NO--> STOP, see staff**
2) **Which UIC Program/College do you attend?_____**
3) **Are you a PATIENT of UI Health Medical Center? ❑YES ❑NO**

4) _____ _____ _____
Who is your primary care physician (PCP) or PCP CLINIC name? **Office phone** **MD fax if available**

Please answer the following questions to help us determine if you are eligible to get a FLU SHOT today. ***If the question is not clear, please ask.***		**NO**	**YES**
5)	Have you received a flu shot in the past?	❑	❑
6)	Do you have a fever today?	❑	❑
7)	Do you have a **serious** allergy to: egg protein, formaldehyde, hydrocortisone or gentamycin which is contained in today's flu vaccine, FLUARIX? **If yes, describe:**	❑	❑
8)	Have you ever had a **serious** reaction after receiving flu vaccine during your lifetime? **If yes, describe:**	❑	❑
9)	Do you have or ever had Guillain-Barré syndrome, described as acute paralysis? **If yes, you are NOT eligible for a flu shot here today. Please see your Medical Provider for a flu shot**	❑	❑

PLEASE READ AND SIGN BELOW:

I have had the opportunity to read the Influenza Vaccine Information Sheet (VIS) dated 8/2019 and was given a chance to ask questions, which were answered to my satisfaction. I understand the benefits and risks of the vaccine. I request and consent that the vaccination be given to me.
I agree to remain in the area for up to 15 minutes and report back to the pharmacist if I experience any unusual effects post-administration before leaving the premises.
On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the University of Illinois at Chicago, UI Hospital & Health Science Systems, UI Health Pharmacy department, the UIC College of Pharmacy as applicable, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed below. I understand that I am giving UI Health Pharmacy permission to release today's immunization details to my physician, as applicable, to enable UI Health Pharmacy to provide the best possible care, with respect to the vaccination.

_____ **9/12/2019**
SIGN HERE **Date**

**********_FOR STAFF ONLY_ **********

❑ **CAMPUS CARE UIN# VERIFIED**

CONSENT FORM REVIEWER:
Pharmacist Reviewed INITIAL HERE:_____
Student may receive vaccine today

Name of vaccine	LOT # & EXP DATE	DATE ADMNISTERED	VIS DATE	DATE VIS GIVEN TO PT	IM SITE (CIRCLE ONE)	TIME ADMINISTERED
FLUARIX QUAD PF (GSK) 0.5mL	Lot: 99CA4 Exp: 06/30/20	09/12/2019	08/15/2019	09/12/2019	LEFT DELTOID RIGHT DELTOID	

X_____
_ **Signature of P3/P4 Immunizer AND/OR Pharmacist co-signature**