THE OHIO STATE UNIVERSITY
HEALTH PLAN

Appt. time_____

700 Ackerman Road, Suite 1007, Columbus, Ohio 43202 – Phone (614)292-4700

The Ohio State University Health Plan, Inc.
Influenza Vaccination Registration/Consent Form

First Name:_____ **Last Name:**_____ **Phone**:_____

Date of Birth:_____ **Gender: F M** **Employee ID#**_____

Does your job require a flu vaccine? Yes No Are you an employee of the medical center? Yes No

PLEASE ANSWER QUESTIONS BELOW:

Have you read the Vaccine Information Statement?	Yes	No
Are you currently ill or have had a fever in the past 48 hours?	Yes	No
Have you **ever** had a flu shot?	Yes	No
Have you ever had a serious or allergic reaction to a previous flu vaccine?	Yes	No
Do you have a history of Guillain-Barre Syndrome (GBS)?	Yes	No
Do you have a severe allergy to eggs or egg protein?	Yes	No
Do you have a severe allergy to gentamicin?	Yes	No
Do you have an allergy to formaldehyde?	Yes	No
Allergic reaction does **NOT** include redness, swelling or pain at the injection site; it **DOES INCLUDE**, but is not limited to the following: shortness of breath, systemic rash, hives, swelling of lips, tongue, mouth or throat, anaphylaxis		

Please review the PATIENT INFORMATION form and read the following before signing.

I, the undersigned, hereby consent to administration of the influenza vaccine to me. I have read fully the information about the risks and benefits of the flu vaccine, as set forth on the Center for Disease Control published Vaccine Information Statement sheet about flu shots, and I have been given an opportunity to ask questions, which have all been answered to my satisfaction. I hereby release The Ohio State University Health Plan, Inc, its affiliates and subsidiaries, and each of its employees, agents and representatives, from all liability as a result of administration of this vaccine.

_____ _____
Signature Date

******Medical Center Employees ******
A completed copy of this Influenza Vaccination Registration/Consent will be sent to Employee Health Services, McCampbell Hall, 1581 Dodd Drive, Columbus, Ohio 43210, by Fax to: (614) 293-8018, or email to: employeehealth@osumc.edu for compliance documentation.

For OSU Health Plan Use Only

Administered under authority of Robert Cooper, MD

Injection Site: Deltoid L R

Administered by Name of Employee_____ **Date**_____

Flu Vaccine Name and Manufacturer: Fluarix by GlaxoSmithKline

Lot #: _____ **Expiration Date:** _____

Needle: 25G 1" 0.5 ml 27G 5/8 " 0.5ml