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: _____ Employee ID#_____

Flu Compliancy entered into Enterprise Health by December 15, 2025:

Employee of: Med Center CON COM Vet Med Childcare COPh COD Other _

PLEASE ANSWER QUESTIONS BELOW:

Have you been given and read the 1/31/2025 Vaccine Information Statement?	No
Are you currently ill or have had a fever in the past 48 hours?	No
Have you **ever** had a flu shot?	No
Have you ever had a serious or allergic reaction to a previous flu vaccine?	No
Do you have a history of Guillain-Barre Syndrome (GBS)?	No
Do you have a severe allergy to eggs or egg protein?	No
Do you have a severe allergy to gentamicin?	No
Do you have an allergy to formaldehyde?	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

For OSU Health Plan Use Only

Administered under authority of Robert Cooper, MD

Injection Site: Deltoid L R

Administered by: _____Date_____

Flu Vaccine Name and Manufacturer: Fluarix by GlaxoSmithKline

Lot #: _____ Expiration Date: _____

Needle: 25G 1" 0.5 ml 25G 5/8" 0.5ml 22G 1 ½" 0.5ml