

Consent for Immunization

Name:	DOB:	RU ID#:
Are you feeling sick today?	Yes / No	
Do you have any allergies to medication, food, a vaccine component or latex	Yes / No	
Female patients: Is there a chance you may become pregnant in the next month?	Yes / No	
Have you had any serious reactions after receiving a vaccine?	Yes / No	
Do you have any long term health problems like heart disease, lung disease, asthma, kidney disease, metabolic disease (eg diabetes), anemia, or other blood disorder?	Yes / No	
Any immune system problems, cancer, leukemia, HIV/AIDS?	Yes / No	
Within the last 3 months, have you taken any medication affecting your immune system?	Yes / No	
Have you had any seizures, brain or other nervous system problems?	Yes / No	
Have you given or received any blood products or gamma globulin during the past year?	Yes / No	
Have you had any live virus vaccines like yellow fever, MMR, oral polio, chicken pox within the last 4 weeks?	Yes / No	
Explain any Yes answers:		
I have been provided with the Vaccination Information Sheet (VIS) for the following vaccine that will be administered today: Influenza Vaccine (VIS 8/7/15)		
I authorize Rutgers Student Health to administer this vaccine. I have been made aware of certain risks that may be associated with this immunization. I have been instructed to wait 20 minutes at the clinic in the event I have an adverse reaction following my injection. I have had the opportunity to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and request the vaccine be given to me.		
_____		Date: _____
Student Signature		
<i>If Student is under the age of 18:</i>		
_____		Date: _____
Parent/Guardian Signature		

Print Parent/Guardian Name		
_____	_____	_____
Verbal Witness Signature	Date	Verbal Witness Signature Date
Vaccine: Fluarix Lot#: _____ Exp.Date: _____ Mfg: GSK		
Administered by: _____ Date: _____		