NorthShore University HealthSystem

FLU CONSENT FORM

INFLUENZA VACCINE CONSENT 2018

Name:	**Date:**
Employee ID:	**Last 4 Digits of SSN:**
Department:	**Manager's Name:**
Email:	**Cell Phone:**

Employee ☐ Volunteer ☐ Student ☐ Intern ☐ Resident ☐ Physician ☐ Other ☐ _____

Check all locations that apply:

Evanston ☐ Glenbrook ☐ Highland Park ☐ Skokie ☐ Medical Group ☐ 1301 Central ☐ 4901 Searle ☐

Other ☐ _____

Select Yes or No for the following questions:

Have you ever had a serious reaction to a previous dose of influenza vaccine?	Yes ☐ No ☐
Are you allergic to eggs or eggs products?	Yes ☐ No ☐
Do you have a history of Guillian-Barre syndrome (GBS)?	Yes ☐ No ☐
Do you have a disease or are you receiving treatment that may compromise your immune system?	Yes ☐ No ☐
Are you currently taking steroids for any reason?	Yes ☐ No ☐
Are you allergic to Latex?	Yes ☐ No ☐
Do you have an active neurological disorder?	Yes ☐ No ☐
Have you ever been told that you are allergic to Thimerosal?	Yes ☐ No ☐
Do you have a fever or active infection today?	Yes ☐ No ☐
Do you have any questions about the vaccine?	Yes ☐ No ☐

I have read the Vaccine Information Statement about the influenza vaccine located on PULSE, employee*Connect* and/or northshore.org. I acknowledge that the information I am providing is true to the best of my knowledge and that knowingly submitting a false record will result in disciplinary action up to and including termination. I recognize that the influenza vaccine may not prevent me from developing the specified disease. I also recognize there is a remote possibility that I could experience an adverse side effect from the immunization.

If I have an EPIC record at NorthShore University HealthSystem, I also consent that my EPIC record will be updated to indicate I have had the flu shot.

☐ Check the box if you consent to have your EPIC record updated to indicate you had the flu shot.

Signature:	**Date:**
Lot# & Expiration:	**Deltoid (arm): Right ☐ Left ☐**
Name of clinician:	**EID of clinician:**