Infection Control
September 2018-March 31, 2019 Influenza Vaccination Form

Name (Please Print Legibly)____

Date: _______________________________ **Date of Birth:** ___________________________________

Department: _________________________ **Cost Center/School/Agency:** ____

Home Address:____**City:**________________________**ZIP:** ___________________

CIRCLE ONE:

Employee (on HMC's payroll) ,
Resident physician, Nurse Practitioner or PA (on HMC's payroll)
LIP (Attending physician, Advance Practice Nurse, PA (not on HMC's payroll)
Adult Student/Trainees and Volunteers, Affiliate organization____
Other Contracted Personnel (example HPMS employees), Affiliate organization____________________________________

A checkmark below indicates that I have one of the following conditions:	*Work Setting (check one):*
____ Have you received the flu vaccine before ____ Allergy to eggs (Oc. Health has egg free vaccine available) ____ Guillain-Barre Syndrome or any other neurological condition (s) ____ Acute febrile illness	_____ Direct Patient Care (clinical) _____ Non-Patient Care (non-clinical)

AUTHORITY TO ADMINISTER INFLUENZA VIRUS VACCINE

I have had the opportunity to ask any questions concerning the vaccine and I understand that the consequences of the use of this vaccine cannot always be predicted in any one particular individual. It is possible that I may not react favorably to the influenza vaccine. With full knowledge of this and having been offered the CDC's Influenza Vaccine Information sheet, by signing this form ***I consent*** to the administration of this vaccine and I assume all risk for possible harmful results, releasing the Medical Center and its personnel from liability for the injection of this vaccine. I also assume the responsibility in reporting to the personnel in charge of the administration of this vaccine any and all unusual symptoms and feelings immediately, should any arise while receiving or after receiving this vaccine.

Signature of Healthcare Worker Receiving Vaccination:

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This Section to be completed by Vaccine Administrator:

VIS form dated: 8/7/2015 provided to employee on the above date. Lot # ____2MA5F
Vaccine utilized__Fluarix quadrivalent_______ Manufacturer: GSK NDC: 58160-898-52

R : L . ____________________________________ Dose 0.5ML
Site (deltoid) Signature of Vaccine Administrator

If you have "Taken Elsewhere" (Flu Vaccination not taken at Hurley Medical Center)
Location where you received your vaccination: ____________________________ Date vaccination was given elsewhere: ___________
If documentation of vaccination is available please attach to this form.