LSU Health
Healthcare Network

MUST BRING THIS FORM WITH YOU
FORM MUST BE COMPLETED BEFORE ARRIVAL

PLEASE PRINT – NAME MUST MATCH ID/INSURANCE

Legal Name: ______________________________

Date of Birth: ______________________________

Nursing _____	Faculty _____
Medicine _____	Staff _____
Allied Health _____	Student _____
Graduate Studies _____	Resident_____
Public Health _____	Fellow_____
Dentistry _____	
Other ___________	

INFORMED CONSENT: INFLUENZA (FLU) VACCINATION 2021/2022

Before agreeing to receive the flu vaccine, please:

• Take time to answer the following questions.
• Take time to read and retain the current CDC INFLUENZA (FLU) VIS (Vaccine Information Statement) provided to you.
• If you have any questions, talk to your doctor or the person administering your shot. The information you provide is private and confidential and will not be used for any other purpose.
• If you have any major medical conditions, please first discuss and obtain advice from your treating doctor.

	YES	NO
1 Did you experience any significant problems after previous flu vaccinations?		
2 Are you ill at the moment? Do you have a fever greater than 100.4?		
3 Are you allergic to eggs, chicken feathers or any egg products?		
4 Have you been diagnosed with Guillain-Barre Syndrome in the past?		

Risks that may be associated with your flu shot:

• The flu vaccine is generally well-tolerated.
• Like all medicines, vaccines may have side-effects. Some redness, soreness or swelling is common at the injection site, but this usually settles within a few days. An allergic reaction can also occur after you leave, if severe seek emergency care immediately.
• Some people have a slight fever, muscle aches, headache, and may feel a bit unwell for a few days after vaccination. These 'flu-like symptoms do not mean you have the flu.
• Guillain-Barre Syndrome is rarely associated with influenza vaccination (1 in 2 million), although a direct relationship has not been established.

I have read and understand the information above and on the 8/6/2021 VIS from the CDC and any questions that I may have had have been answered. I give consent to LSU Healthcare Network to vaccinate me for the influenza (flu) virus.

SIGNATURE (recipient or parent/guardian) ______________________________________ DATE ______________

If patient is a minor, name & relationship to minor ____

FOR OFFICE USE ONLY

FLU VACCINE MANUFACTURER _________________ LOT NUMBER ______________________ EXP DATE ______________

SITE OF INJECTION – ARM (deltoid) (circle) Left OR Right

VACCINE ADMINISTRATOR SIGNATURE __________________________________ ADMINISTRATION DATE ______________