Northern Light

Influenza Vaccine Administration Record and Consent

NORTHERN LIGHT HEALTH EMPLOYEE	*** NON-EMPLOYEE** ***A person who does not receive a paycheck from a Northern Light member.***
Name _____	**Name** _____
DOB *(month/day/year)* _____/_____/_____	**DOB** _____/_____/_____ **Badge #** _____
Employee # _____	**Full SS#** *(required)* _____ - _____ - _____
Employer _____	**Telephone #***(Cell)*_____ *(Work)*_____
***** PLEASE FORWARD FLU VACCINE RECORDS TO YOUR MEMBER FLU VACCINATION COORDINATOR. ***** *A list of coordinators can be found under common documents on the Flu Vaccination Information Portal.*	**Home Address** _____ **Work Location/Employer** _____ ***Please check box indicating your position*** ☐ Non-Employed Credentialed Medical Staff ☐ Travel Nurse ☐ Student ☐ Contractor ☐ Volunteer ☐ Other_____

Questions:

1. Have you ever had a flu vaccine? **Y or N**
2. If yes, did you have an adverse reaction? **Y or N**
3. Are you allergic to eggs, thimerosal, or latex? **Y or N**
4. Do you have a fever, illness, or active infection? **Y or N**
5. Have you ever had Guillain-Barre' syndrome? **Y or N**
6. I understand I should wait in the area **20 minutes** after I receive my vaccine and will seek immediate medical treatment for any signs or symptoms of adverse or allergic reactions after receiving the Influenza vaccination. **Y or N**
7. I am 18 years old and can legally consent for the person below to get the influenza vaccine. I freely and voluntarily give my signed permission for this vaccine as well as medications given in an emergency for an allergic reaction. **Y or N**
8. Do you have any questions about the vaccine? **Y or N**

I have received and read, or have had read to me, the information contained in the Vaccine Information Statement (VIS) about influenza vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine, and request that the influenza vaccine be given to me. I have been advised to seek IMMEDIATE medical treatment for any signs or symptoms of adverse or allergic reactions after receiving influenza vaccination.

☒ ***Vaccine:*** *Influenza* ***Date of VIS:*** *8/6/21*

I request that my flu vaccine record be entered into my personal medical record in Cerner and shared with my employer.

Signature of Patient: _____ **Date** (Mo/Day/Yr):_____/_____/_____

****

Mfr./Lot#	Dose, Route, Site	Provider's Signature & Title
	IM, 0.5ml, **(Circle which side)** **R L Deltoid**	

GIVE A COPY TO EMPLOYEE AND ENCOURAGE THEM TO RETAIN A COPY AND SHARE ONE WITH THEIR PCP!