**FLU VACCINATION INFORMATION/CONSENT FORM**

Edward-Elmhurst HEALTH

| Name: | | Date: | |
|---|---|---|---|
| Employee ID #: | Date of Birth: | | Phone #: |
| Department: | | Manager: | |
| Team Member Status: ☐ Employee ☐ Volunteer ☐ Student ☐ Intern ☐ Resident ☐ Physician ☐ Other | | | |

**Health Questionnaire – PART 1**

| | NO | YES |
|---|---|---|
| 1. Have you had a severe allergic reaction to an influenza vaccine or an influenza vaccine component? (A severe allergic reaction would include respiratory distress, rapid heartbeat, or vomiting requiring emergency medical attention or prescription medication) | ☐ | ☐ |
| 2. Have you had Guillain-Barre within 6 weeks of receiving an influenza vaccine? | ☐ | ☐ |

If you answered YES to either of these questions, you should consult with your physician. You may elect to receive the influenza vaccine in your physician's office OR ask your physician to complete a REQUEST FOR MEDICAL EXEMPTION form. You must submit the exemption form to Employee.Health@EEHealth.org for review before **November 1st, 2022**

**Health Questionnaire – PART 2**

| | NO | YES |
|---|---|---|
| 1. Have you had an allergic reaction to eggs or egg products? | ☐ | ☐ |
| 2. Do you have an allergy to latex? | ☐ | ☐ |
| 3. Do you currently have any active infection, including COVID, fever (>101.0º F), or flu-like symptoms? | ☐ | ☐ |
| 4. Are you 65 years of age or older? | ☐ | ☐ |

**Consent:**

I, the undersigned, give my consent to receive an influenza vaccination of 0.5mL IM. I understand that occasionally some of the following symptoms may occur following the administration of this vaccine:

- Soreness at the injection site for 1-2 days.
- Fever, tiredness, body aches (flu-like symptoms) for 1-2 days.
- Slight redness and swelling at the site of injection.

**I have received a copy of the Influenza Vaccine Information Statement. Based upon this information, I have had the opportunity to ask questions which have been answered to my satisfaction and I understand the benefits and risks of flu vaccination. Furthermore, I have read the above information and am not aware of any reasons that prohibit me from receiving the vaccine. I, the undersigned, do hereby consent to allow the physicians, nurses, pharmacists and/or medical assistants associated with NorthShore - Edward-Elmhurst Health to administer the flu vaccine. I agree that Employee Health may transfer a record of this vaccination to my Epic medical record if I have one.**

**Signature** ______________________ **Date** ______________

| | | | |
|---|---|---|---|
| **Manufacturer:** | | **Date Given:** | **Time:** |
| **Lot Number:** | | **Site:** | ☐ Left Deltoid ☐ Right Deltoid |
| **Expiration Date:** | | **Administered By Signature:** | |
| **VIS Date:** | **8/6/2021** | | |