**FLU VACCINATION INFORMATION/CONSENT FORM**
**Flu Season 2021-2022**

Edward-Elmhurst HEALTH | Healthy Driven

EMPLOYEE/VOLUNTEER/HEALTH CARE WORKER INFORMATION

Name & Title_______________________________________________ Date of Birth ________________________

Department Name/Number _____________________________________ Employee ID #______________________

**HEALTH INFORMATION – 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 this form to Edward-Elmhurst Employee Health for review before **November 12*, 2021*.**

**HEALTH INFORMATION – PART 2** NO YES

1. Have you had an allergic reaction to eggs? ☐ ☐

2. Do you have an allergy to any flu vaccine components? ☐ ☐

3. Do you currently have any active infection, including COVID, fever, or flu-like symptoms? ☐ ☐

4. Do you have an allergy to latex? ☐ ☐

I, ________________________________________give my permission to Edward-Elmhurst Employee Health (EEH) to administer the Flu Vaccine to me. I understand that EEH relies on the Health Information provided by me in administering the Flu Vaccination. I understand that EEH, its employees and physicians are not responsible for any untoward or negative effects of vaccination due to inaccurate or incomplete information provided by me above. *I certify that I have read, understand, and have been provided a copy of the current Vaccine Information Statement for this vaccine which explains the purpose, side effects, and possible complications of this vaccine.*

__________________________________________ ________________________________
Employee Signature Date

**Physician Name*:** ________________________________________, **Physician Group**: ☐ Edward Medical Group

☐ Elmhurst Memorial Medical Group ☐ DuPage Medical Group ☐ Elmhurst Clinic ☐ Elmhurst Medical Associates

☐ Other List: ________________________________

*If supplied, this vaccine information will be shared with your physician's office for inclusion in your healthcare record.

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Person giving the injection must complete when vaccine is given:

| Vaccine | Lot# | Exp. Date | Date Given | Inj. Site | Given By |
|---|---|---|---|---|---|

Manufacturer: ________________________________________