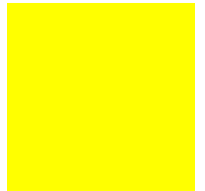




Arizona State University Health Services



2017-2018 Influenza vaccine release form

I have been given a copy and understand the "Vaccine Information Statement" for the disease and vaccine above. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine requested and ask that the vaccine be given to me. I **hereby release ASU from any and all liability from, or in any way connected with, the vaccination.** I certify that the following information is correct to the best of my knowledge.

☐ **Faculty / Staff
With ASU Insurance**

☐ **Faculty / Staff Benefits Eligible
(Insurance not with ASU)**

☐ **Faculty / Staff
Non-Benefits Eligible with ASU**

Answer all questions below by checking the appropriate Yes or No space.

	Yes	No
❖ Are you allergic to eggs, chicken or chicken feathers?	<input type="checkbox"/>	<input type="checkbox"/>
❖ Do you have a fever, acute respiratory or other active infections or illnesses?	<input type="checkbox"/>	<input type="checkbox"/>
❖ Have you had a Flu shot or Flu mist before?	<input type="checkbox"/>	<input type="checkbox"/>
❖ Have you ever had a serious allergic reaction to a Flu shot or Flu mist ?	<input type="checkbox"/>	<input type="checkbox"/>
❖ Are you allergic to Thimerosal used in flu vaccine and some contact lens solutions?	<input type="checkbox"/>	<input type="checkbox"/>
❖ Are you allergic to Latex?	<input type="checkbox"/>	<input type="checkbox"/>
❖ Have you had chemotherapy or immunosuppressive therapy within the past two weeks?	<input type="checkbox"/>	<input type="checkbox"/>
❖ Do you have an active neurologic disorder?	<input type="checkbox"/>	<input type="checkbox"/>
❖ Have you had Guillain-Barre Syndrome - paralyzing disorder?	<input type="checkbox"/>	<input type="checkbox"/>
❖ Do you have a chronic medical condition such as diabetes, asthma or heart disease?	<input type="checkbox"/>	<input type="checkbox"/>

Information about person to receive vaccine. Please print.

Last name: _____

First name: _____ Initial: _____

ASU ID #: _____

Date of birth (Month/Date/Year): _____

Signature _____

Date _____

For clinic/office use

Manufacturer lot number: _____

GSK Lot: 4799F EXP: 06/18/18

Site of injection: _____ Left Right Deltoid

Signature and title of vaccine administrator _____

Date vaccinated: _____



Bill to my ASU account.