THE STATE UNIVERSITY OF NEW JERSEY
RUTGERS
Occupational Health Department
11 Bishop Place • New Brunswick • New Jersey 08901-1180
Office: 732/ 932-8254 Ext. 221 • FAX: 732/ 932-7199

INFLUENZA IMMUNIZATION CONSENT FORM

Please Print

Name: ____ Date of Birth: ______________
Department Address: ____
Phone # (either department or personal): ________________________________
Department: ______________________________ Campus: __________________

To the best of my knowledge I do not have any of the following:

1. Sickness with a fever today.
2. A severe allergy (anaphylaxis) to eggs.
3. History of diagnosis of Guillain-Barre syndrome.
   (A viral illness resulting in neurological symptoms.)
4. A serious reaction to the flu shot.
5. Any bleeding disorder, such as hemophilia.

I have been given a copy and have read the information in the Vaccine Information Statement about the inactivated influenza vaccine dated 7/26/11. I have had sufficient opportunity to ask questions which have been answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine and I request that I be immunized with this vaccine.

I UNDERSTAND THAT IF I HAVE ANY COMPLICATIONS FROM THE INFLUENZA VACCINE, I MUST SEEK CARE FROM MY PRIVATE PHYSICAN.

Signature: ___________________________ **Date: _____________**

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FOR CLINIC USE:

Vaccine	Date	Lot#	Manufacturer	Exp Date	Site	Route	Dose	Initials
Influenza		**AFLLA679AA**	**G/S/K**	**Jun 2012**	**LD/RD**	**IM**	**0.5ml**	**JOB/MD/HD**