Davison Health Center

IMMUNIZATION ADMINISTRATION AND CONSENT FORM

Last Name:	**First Name:**	**MI**
Address:	**Phone:( )**	
City:	**State:**	**Zip code:**
Date of Birth: _____/_____/_____ Month / Day /Year	**Gender:**	**Student only - Wesleyan ID:**

Wesleyan Employees/Dependents

- ☐ Health Insurance Eligible
- ☐ Retirees

Wesleyan Students

- ☐ Bill to Student Account
- ☐ Cash $37.00
- ☐ Check # _____

HEALTH HISTORY

Have you had a severe allergic reaction to eggs or Thimerosal? Yes ____ No ____

Are you sick with a fever or respiratory illness today? Yes ____ No ____

Have you had a serious reaction to a flu shot or any vaccine? Yes ____ No ____

Describe_____

Do you have a history of Guillain-Barré Syndrome? (A kind of paralysis) Yes ____ No ____

Is this your first flu shot? Yes ____ No ____

****If I have not had this vaccine before, I will stay for 15 minutes after receiving either vaccine.

By signing this form: I give permission for the flu vaccine to be administered to me. I acknowledge that I have read the current Influenza Vaccine Information Statement(s), have had questions answered to my satisfaction and understand the risks and benefits involved and that I have read or been given a copy of the agency's "Notice of Use and Disclosure of Protected Health Information". On behalf of myself as well as my administrators and assigns, hereby release and forever discharge Wesleyan University and its trustees, employees and agents from any and all liability and/or obligation of any kind resulting from or in any way associated with the administration of this vaccine. I give my permission for the VNA HealthCare to release medical or other information necessary to bill my Medicare or insurance plan for the vaccination(s) and to keep my signature on file. I agree to pay all charges that are not covered by Medicare or insurance.

Signature of Recipient/Legal Representative _____

Date _____

_____FOR CLINIC USE ONLY. DO NOT WRITE BELOW THIS LINE_____

Vaccine	**Date Administered**	**Injection Site (L arm or R arm)**	**Administered by:**	**Lot#**	**Manufacturer**
Influenza		LA or RA			