

# AUM Student Health Center

## Vaccine Consent and Administration Record

Patient Information: Last Name Green First Name MARY T. Date of Birth 7/17/63

Address: 6516 Cypress Drive

Phone: 3470 Primary Care Provider Kirby Parker

| Screening Questions:                                                                                                                                                        | Yes                      | No                                  | Don't Know               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------|--------------------------|
| 1) Are you sick today? ( cold, fever, acute illness)                                                                                                                        | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2) Do you have allergies to any foods, medications or latex?<br>(For example: eggs, gelatin, neomycin, thimerosal.)<br>List _____                                           | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 3) Do you take anticoagulation medicine? (Ex: warfarin, Coumadin or other blood thinners).                                                                                  | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 4) Do you have any long-term health problems with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorders? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 5) Have you had a seizure, brain or other nervous system problem? (Ex: Guillain-Barre syndrome?)                                                                            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 6) For women: Are you pregnant or nursing? Could you become pregnant in during the next month?                                                                              | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

Consent for Services: I have been provided with the Vaccine Information Sheet corresponding to the vaccine that I am receiving. I have read or have had explained the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I request that the vaccine be given to me or the person named above for whom I am authorized to make this request,

Signature Mary T Green Date 7 Oct 19

Administration Date 10/7/19 Route: IM LD or RD Volume: 0.5cc

Administrator [Signature] VIS Date 08/15/2019

Manufacturer: GSK Fluarix® Quadrivalent Lot # 3L32N Expires 06/30/2020

LOT: 3.376  
EXP: 06/30/20

NDK 06180-006-41

Influenza  
Vaccine  
FLUARIX QUADRIVALENT  
2019/2020 Formula

0.5 mL  
Mfg. by  
GlaxoSmithKline  
Biologics