

AUM Student Health Center
Vaccine Consent and Administration Record

Patient Information: Last Name HARRINGTON First Name MARIE Date of Birth 08/14/1967
Address: 2900 Fernway Dr 36111
Phone: 3994850 Primary Care Provider BCBS

Screening Questions:	Yes	No	Don't Know
1) Are you sick today? (cold, fever, acute illness)	☐	☒	☐
2) Do you have allergies to any foods, medications or latex? (For example: eggs, gelatin, neomycin, thimerosal.) List _____	☐	☒	☐
3) Do you take anticoagulation medicine? (Ex: warfarin, Coumadin or other blood thinners).	☐	☒	☐
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?	☐	☒	☐
5) Have you had a seizure, brain or other nervous system problem? (Ex: Guillain-Barre syndrome?)	☐	☒	☐
6) For women: Are you pregnant or nursing? Could you become pregnant in during the next month?	☐	☒	☐

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 Marie H Date 9-20-19

Administration Date 9/20/19 Route: IM ☒ LD or RD ☐ Volume: 0.5cc

Administrator Jean VIS Date 08/15/2019

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