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AUM Student Health Center
Vaccine Consent and Administration Record

Patient Information: Last Name First Name Date of Birth

Zachar Peter 8/10/63

Address: 8424 Marsh Point Drive Montrose 36117

Phone: 3311 Primary Care Provider Jon Dylor

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 Peter Zachar Date 9-22-17

Administration Date 9/22/17 Route: IM LD or RD Volume: 0.5cc

Administrator [Signature] VIS Date 8/7/2015

Manufacturer: GSK Fluarix® Quadrivalent Lot # TL54R Expires 06/12/2018

