

AUM Student Health Center  
Vaccine Consent and Administration Record

Patient Information: Last Name Reno First Name Seth Date of Birth 3/27/83  
Address: 5107 Chapel Chase Lane, Huntersville, NC 28078  
Phone: 614-595-3547 Primary Care Provider Alyson Suggs

| 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 <u>All-illies, -mycins, dehydrants, peanuts, shellfish</u> | <input checked="" type="checkbox"/> | <input 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 [Signature] Date 9-24-19

Administration Date 9/24/19 Route: IM (LD) or RD Volume: 0.5cc

Administrator Alyson VIS Date 08/15/2019

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