

AUM Student Health Center
Vaccine Consent and Administration Record

Patient Information: Last Name

First Name

Date of Birth

Faust Wanda 7, 2, 52

Address: 195 Old Barn Rd

Phone: 244-3678 Primary Care Provider Tolentino

Screening Questions:

Yes

No

Don't Know

1) Are you sick today? (cold, fever, acute illness)

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2) Do you have allergies to any foods, medications or latex?

(For example: eggs, gelatin, neomycin, thimerosal.)

List _____

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3) Do you take anticoagulation medicine? (Ex: warfarin, Coumadin or other blood thinners).

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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?

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5) Have you had a seizure, brain or other nervous system problem? (Ex: Guillain-Barre syndrome?)

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6) For women: Are you pregnant or nursing? Could you become pregnant in during the next month?

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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

[Handwritten Signature]

Date

10/15/16

Administration Date

10/15/19

Route: IM

LD or RD

Volume: 0.5cc

Administrator

[Handwritten Signature]

VIS Date 08/15/2019

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