

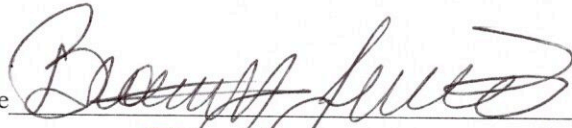
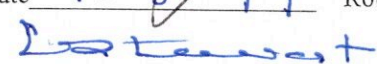
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AUM Student Health Center
Vaccine Consent and Administration Record

Patient Information: Last Name Jenkins, Brittaney First Name _____ Date of Birth 9/15/89
Address: 2845 Zelcer Rd. Apt C-2
Phone: _____ Primary Care Provider Roger Glymph

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  Date 09/08/17
Administration Date 9-8-17 Route: IM ☒ LD or RD Volume: 0.5cc
Administrator  VIS Date 8/7/2015

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