

AUM Student Health Center
Vaccine Consent and Administration Record

Patient Information: Last Name

First Name

Date of Birth

Bailey Jennifer 6/9/72

Address: 128 Bowen Bend Wetumpka 36083

Phone: 398-2528 Primary Care Provider BC/BS of A

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 Jennifer A Bailey Date 11/7/19

Administration Date 11/7/19 Route: IM LD or RD Volume: 0.5cc

Administrator [Signature] VIS Date 08/15/2019

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