AGE:

THE CITY UNIVERSITY OF NEW YORK

IMMUNIZATION CONSENT FORM FOR INFLUENZA VACCINATIONS

COLLEGE	TELEPHONE#	EMERGENCY CONTACT#		
LAST NAME	FIRST		MIDDLE	
☐ MALE ☐ FEMALE ☐ MTF ☐ FTM	MOTHER'S MAIDEN NAME	DATE OF BIRTH MONTH DAY YEAR		
ADDRESS	APT.	CITY	STATE	ZIP

SCREEN A

ALL INFORMATION PROVIDED WILL BE KEPT CONFIDENTIAL

PLEASE CHECK THE APPROPRIATE BOX (ES) BELOW

1. Do you have health insurance? ☐ YES ☐ NO
2. If yes, who is your health insurance carrier?

☐ Sponsored by Parent/Guardian	☐ Health Care Exchange Plan	**Covered by:**
☐ Medicaid	☐ Child Health Plus	☐ Spouse
☐ Private (ex.Aetna, BlueCross, HIP)	☐ Uninsured	☐ Domestic Partner
☐ Other: (specify) _____	☐ Underinsured	☐ Employee

SCREEN B

	CIRCLE ONE	
1. Are you 50 years or older?	YES	NO
2. Are you feeling sick with anything other than a cold today?	YES	NO
3. Have you ever had a severe reaction to an immunization?	YES	NO
4. Do you have a history of nerve or muscle disorders such as GBS, seizures or cerebral palsy?	YES	NO
5. Do you have an allergy to chicken eggs or any vaccine component?	YES	NO
a. What type of allergic reaction did you have to eggs or vaccine component? _____		
6. Do you have allergies to medication or latex?	YES	NO
a. If so, please list: _____		
b. What type of allergic reaction did you have to the meds or latex ? _____		
7. Do you have any chronic conditions? (ex. Diabetes, asthma, anemia)	YES	NO
8. Are you pregnant now?	YES	NO

Interviewed by: _____

CONSENT

I have read the Important Information About Influenza Vaccine form(s) about the disease(s) and the vaccine(s). I have had a chance to ask questions which, if any, were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated below be given to me or to the person named for whom I am authorized as parent, guardian, or long term custodian to make this request.

Yo he leido del formulario la Informacion Importante Sobre la Vacuna Influenza acerca de la(s) enfermedad(es) y la(s) vacuna(s). He tenido la oportunidad de hacer preguntas las cuales, si hubo algunas, fueron contestadas a mi satisfaccion. Creo que comprendo los beneficios y riesgos de la(s) vacuna(s) y pido que me den la(s) vacuna(s) indicada(s) mas abajo a mi o a la persona nombrada por quien estoy autorizado(a) como padre, guardian, o cuidador por largo tiempo para hacer esta peticion.

PATIENT SIGNATURE **DATE**

FIRMA DEL PACIENTE _____ **FECHA** _____

OFFICE USE ONLY

Vaccine / Manufacturer I.D.	Injection or Nostril Site	V.I.S.	Lot #	Expiration Date
Influenza /	**LUA / RUA/ Nostril**			

Inoculator Signature: **Date:**