Old Dominion University
Student Health Services
Seasonal Influenza Consent Screening Sheet

Your Name: ______________________________________________________________________________

Date of Birth: ___________________________ Today’s Date: _______________________

Are You:  □ Student UIN: ____________________  □ Faculty/Staff UIN: ____________________

1.  Do you have a serious allergy or other reaction to:
   Any vaccine or vaccine component? □ Yes □ No
   Egg or Egg Products? □ Yes □ No

2.  Do you currently have a moderate to severe acute illness?
   If you are unsure, ask your doctor or nurse. □ Yes □ No

3.  Have you ever had Guillain Barré Syndrome (GBS)?
   (a serious neurological disorder which starts with numbness in the legs and progresses to muscle weakness and paralysis) □ Yes □ No

Seasonal Influenza Consent Statement

I have received the vaccine information statement for Seasonal Influenza (flu) vaccine. I have read (or have had explained to me) the information on this sheet. I have had a chance to ask questions which were answered to my satisfaction. I believe that I understand the benefits and risks of the vaccine I am receiving.

Signature: ________________________________  Date: ________________________________

For Office Use Only

VACCINE NAME      SITE GIVEN      LOT NO.     EXP. DATE     VIS DATE
Influenza 0.5cc Fluvirin  □R / □L Deltoid  158005     06/2016     08/07/2015
Influenza 0.5cc Afluria  □R / □L Deltoid  U50809     06/30/2016  08/07/2015

Signature of person administering vaccine: _____________________________________________

Date administered: __________________________________________________________________

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