Seasonal Flu Vaccine Form
SMU Student Health Center

Name: Last_____ First_____ Date of Birth_____ SMU ID#_____

Phone#_____

Please circle:
Status: Student Faculty Staff Retiree Other_____

Aetna <u>Student</u> Health Insurance? Yes No

If Yes, current address required: _____
Street **City/St/Zip**

This vaccine is for seasonal flu, not H1N1 vaccine.

1. Do you feel ill today or have you had a fever, diarrhea or vomiting in the past 2 days? Yes No
2. Have you ever had a severe reaction to any vaccine which required medical care? Yes No
3. Are you allergic to eggs, preservatives (thimerosal), or latex? Yes No
4. Have you had Guillain-Barre Syndrome, a neuro-muscular condition? Yes No
5. Are you taking any blood-thinning medications (warfarin, daily aspirin) Yes No
6. For Women: Are you pregnant? Yes No
7. Have you taken Relenza, Tamiflu or Flumist in the past 2 weeks? Yes No

I have read the Vaccine Information Sheet (VIS) and I have been given the opportunity to ask questions that have been answered to my satisfaction. I understand the benefits and risks of the vaccine. I consent for the administration of the vaccine. I understand that if I experience any side effects, it will be my responsibility to follow-up with my own physician or at the Health Center.

_____ _____ ** **Please initial that you have reviewed our Health**
Signature of Patient Date **Information Privacy Policy.**

_____
Initials

<u>Office Use Only</u>

Vaccine/ Manufacturer: <u>Fluvirin/Novartis</u> Lot #: <u>9721501</u> Exp. Date: <u>5/2010</u>

Route: <u>IM</u> Admin. Site: <u>R or L Deltoid</u> VIS Date: <u>8-11-09</u> Admin. Date: <u>as above</u>

Administrator:_____ Access ASI Cash Check HR C/D NC
$ 5
$25