# IMMUNIZATION CONSENT FORM

**NAME**:_____ **STUDENT ID#** _____
(Last) (First) (M.I.)

**ADDRESS**:_____

**CITY:** _____ **STATE:** _____ **ZIP CODE:** _____

**PHONE:** ( ) **SEX:** M / F **INSURANCE PLAN:** [ ] NEIU
[ ] PERSONAL

**BIRTHDATE:** _____ / _____ / _____ **AGE:** _____ [ ] NONE

***Precautions and Contraindications: Please check YES or NO for each question***

| | | YES | NO |
|---|---|---|---|
| 1 | Do have sensitivity to latex? | | |
| 2 | Are you allergic to chicken eggs or egg products? | | |
| 3 | Are you allergic to Thimerosal (a preservative found in some cleaning products)? | | |
| 4 | Are you exhibiting symptoms other than mild coughing, runny nose and/or diarrhea? | | |
| 5 | Do you have a history of Guillan-Barre Syndrome or active neurological disorder? | | |
| 6 | Have you ever had a serious reaction after receiving the influenza and/or pneumonia vaccine? | | |
| 7 | Are you currently receiving blood thinners such as Coumadin or heparin? | | |
| 8 | Have you received and read the Vaccine Information Statement? | | |

| | **For Women** | YES | NO |
|---|---|---|---|
| 9 | Are you pregnant or suspect you are pregnant? If yes, please talk to the nurse before receiving the influenza vaccine. | | |

**INFLUENZA VACCINE:**

[ ] Right Deltoid _____ (Nurse Initials)

[ ] Left Deltoid _____(Nurse Initials)

Expiration Date: _____ LOT No. _____

_____
Student Signature

_____ _____
Nurse's Signature Date of Service