THE OHIO STATE UNIVERSITY
HEALTH PLAN

Appt. time_____

700 Ackerman Road, Suite 1007, Columbus, Ohio 43202 – Phone (614)292-4700

# The Ohio State University Health Plan, Inc.
# Influenza Vaccination Registration/Consent Form

**First Name:**_____ **Last Name:**_____ **Phone:**_____

**Date of Birth:**_____ **Employee ID#**_____

**Does your job require a flu vaccine? Yes No Are you an employee of the medical center? Yes No**

***PLEASE ANSWER QUESTIONS BELOW:***

| | | |
|---|---|---|
| Have you been given and read the 8/6/2021 Vaccine Information Statement? | Yes | No |
| Are you currently ill or have had a fever in the past 48 hours? | Yes | No |
| Have you **ever** had a flu shot? | Yes | No |
| Have you ever had a serious or allergic reaction to a previous flu vaccine? | Yes | No |
| Do you have a history of Guillain-Barre Syndrome (GBS)? | Yes | No |
| Do you have a severe allergy to eggs or egg protein? | Yes | No |
| Do you have a severe allergy to gentamicin? | Yes | No |
| Do you have an allergy to formaldehyde? | Yes | No |
| Allergic reaction does **NOT** include redness, swelling or pain at the injection site; it **DOES INCLUDE**, but is not limited to the following: shortness of breath, systemic rash, hives, swelling of lips, tongue, mouth or throat, anaphylaxis | | |

## *Please review the PATIENT INFORMATION form and read the following before signing.*

I, the undersigned, hereby consent to administration of the influenza vaccine to me. I have read fully the information about the risks and benefits of the flu vaccine, as set forth on the Center for Disease Control published Vaccine Information Statement sheet about flu shots, and I have been given an opportunity to ask questions, which have all been answered to my satisfaction. I hereby release The Ohio State University Health Plan, Inc, its affiliates and subsidiaries, and each of its employees, agents and representatives, from all liability as a result of administration of this vaccine.

_____ _____
Signature Date

******Medical Center Employees ******
**A completed copy of this Influenza Vaccination Registration/Consent will be sent to Employee Health Services, McCampbell Hall, 1581 Dodd Drive, Columbus, Ohio 43210, by Fax to: (614) 293-8018, or email to: employeehealth@osumc.edu for compliance documentation.**

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**For OSU Health Plan Use Only**

**Administered under authority of Robert Cooper, MD**

**Injection Site: Deltoid L R**

**Administered by:** _____ **Date**_____

**Flu Vaccine Name and Manufacturer: Fluarix by GlaxoSmithKline**

**Lot #:** _____ **Expiration Date:** _____

**Needle: 25G 1" 0.5 ml 25G 5/8" 0.5ml 22G 1 ½" 0.5ml**