

# HANCOCK COUNTY MEMORIAL HOSPITAL INFLUENZA VACCINATION GUIDELINES/CONSENT for 2009 - 2010

If you (the patient) respond "YES" to any of the questions below, prior approval to administer the vaccination must be obtained from the healthcare provider.

- Y or N      Have you ever had a severe (anaphylactic) reaction to the Influenza shot or any other vaccine?
- Y or N      Have you ever had an allergy to latex or a latex product?
- Y or N      Are you allergic to eggs or egg products?
- Y or N      Are you allergic to Thimerosal-containing products or Mercury-containing products?
- Y or N      Do you have a history of Guillian-Barre's Syndrome?
- Y or N      Do you currently have an acute febrile respiratory illness or other active infection at this time?  
(fever)

The nurse may administer the Influenza vaccine if the patient responds "NO" to ALL of the above questions.

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## Patient Consent

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I have read the information above or have had the information explained to me. I have had a chance to ask questions and these have been answered to my satisfaction. I understand the benefits and the risks of the vaccine and request that the vaccine be given to me, or to the person named below for whom I am authorized to make this request. I accept responsibility for seeking medical attention for any problem resulting from this vaccination. I authorize billing of this vaccination to my health insurance unless otherwise noted.

I consent to receive this vaccination.

**Patient Signature** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Print Patient Name** \_\_\_\_\_

**Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

*(if child under 18 yrs of age or dependent adult)*

**Relationship to patient (if applicable)** \_\_\_\_\_

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*(This section to be completed ONLY by the nurse/health care provider.)*

**Assessor** \_\_\_\_\_ **Date** \_\_\_\_\_

**Lot #** \_\_\_\_\_ **Site** (circle one) R L Deltoid

**Exp date** \_\_\_\_\_ **Date given** \_\_\_\_\_

**Nurse Signature** \_\_\_\_\_

**VIS given 8/11/09**

BMC     GMC     KMC     WMC