BAYLOR SCOTT & WHITE HEALTH
INFLUENZA VACCINE CONSENT AND IMMUNIZATION RECORD

SCREENING QUESTIONS: If you answer "yes" to any of the questions, you may not be eligible for flu vaccine today.	**Yes**	**No**
1. Have you ever been diagnosed with severe muscle pains and paralysis (Guillain-Barre Syndrome) within 6 weeks after receiving a flu vaccine?		
2. Have you received a bone marrow transplant within the past 6 months?		
3. Have you had a serious allergic reaction to any vaccine including previous flu vaccines?		
4. Are you allergic to Thimerosal? If yes, you may still receive your influenza vaccination from a single-dose syringe. *Flu vaccines in multi-dose vials contain thimerosal to safeguard against contamination of the vial. Most single-dose vials and pre-filled syringes of the flu shot and the nasal spray flu vaccine do not contain a preservative because they are intended to be used once.*		
5. Have you already received a flu vaccination this season?		

PATIENT INFORMATION:

Last Name:	First Name:	Middle Initial:	Date of Birth:

If under 18: Parent/Guardian:

Parent/Guardian Name:	Preferred Phone Number:	Relation to Patient:

DEMOGRAPHIC INFORMATION: If available and you have completed e-Check-In on MyBSWHealth, you do not need to complete the Demographic Information or Health Insurance Section.

Gender: ☐ Male ☐ Female **SSN#:** XXX - XX - ___ ___ ___ ___	**Race:** ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ Black or African American ☐ White	**Ethnicity:** Hispanic or Latino ☐ Yes ☐ No

Street Address:	**City:**	**State:**	**Zip Code:**	**County:**

Preferred Phone Number:	**Email Address:**	**Primary Care Physician:**

HEALTH INSURANCE:

Insurance Company:	**Group Number:**	**Policy Number:**	**Policy Holder Name:**	**Policy Holder DOB:**

☐ **CHECK THIS BOX IF YOU DO NOT HAVE HEALTH INSURANCE COVERAGE OR ARE UNDERINSURED**

By signing below, I attest that all the answers above are true and correct to the best of my knowledge and all my questions have been answered.

I have been provided the opportunity to read, been provided a copy, and/or declined a copy of the Vaccine Information Sheet ("VIS") for the influenza vaccine.

I consent to receiving the influenza vaccine at this time and to allow BSWH to bill for the influenza vaccine.

Signature:	Date:	Time:	Relation to Patient:

For Vaccine Team Only: If completed electronically, this section may be left blank.

Vaccine Manufacturer:	☐ GSK ☐ Sanofi ☐ Seqirus ☐ Other			Date/Time:	
Vaccine Type:	☐ Afluria (MDV) ☐ Afluria (syringe) ☐ Fluad (65+) ☐ Fluarix ☐ Flublok ☐ Flucelvax (MDV)	☐ Flucelvax (syringe) ☐ Flulaval ☐ Fluzone (MDV) ☐ Fluzone (syringe) ☐ Fluzone High Dose (65+)	Administered by:	Site:	☐ Right ☐ Left ☐ Deltoid ☐ Thigh
Lot Number:			Location (Clinic/Facility):		
Expiration Date:			Dose: ☐ 0.5 mL ☐ 0.25 mL		
VIS Edition:	8/6/2021				

Scan doc type: Consent - Immunization

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