JBT Health & Wellness Center
Phone: 503-+494-8665

Flu Vaccine consent for individuals receiving the 2014-2015 flu vaccine

_____, _____ _____/_____/_____
Last name (**please print**) First name (**please print**) Date of birth (mm/dd/yyyy)

Are you a registered patient at OHSU? Y_____ N____
If not, please call 503-494-8505 and ask to be registered as a patient.

PatientType: Post Doc, Student or Spouse/Domestic Partner *(please circle)*

C.O.P.	D.I	Grad Med	LEND	PA	Post-Doc	SOD	SOM	SON	RTx	Spouse

Please answer the following questions with yes or no:

1. Do you have an allergy to eggs? Y_____ N_____
2. Have you ever been paralyzed by Guillain-Barre Syndrome? Y_____ N_____
3. Do you have a moderate or severe illness Y_____ N_____
4. Have you ever had a serious allergic reaction or
   any other problems getting a flu vaccine? Y_____ N_____

Influenza Consent

I have read the information about the influenza vaccine. I understand the benefits and risks and request the vaccine be given to me.

Signature_____

Office use only

TB Test ☐ _____ *Date of vaccination* _____ *Site of Injection (L/R)* *Epic* ☐ *Nuesoft* ☐