



**EMPLOYEE HEALTH SERVICES**  
 57 Bee Street – MSC 213  
 Charleston, SC 29425-2130  
 Telephone (843) 792-2991  
 Fax (843) 792-1200

**INFLUENZA VACCINATION for 2008/09:  
 CONSENT FORM**

**EMPLOYER (Required):**     Hospital/MUHA     University/MUSC     UMA/CFC     Crothall     Sodexo

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
 Age \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ MUSC Employee ID \_\_\_\_\_ Work # \_\_\_\_\_  
 Dept. \_\_\_\_\_ Position \_\_\_\_\_

Please answer the following questions:

YES	NO	
_____	_____	Are you allergic to chicken eggs?
_____	_____	Have you ever had Guillain-Barre Syndrome?
_____	_____	Have you ever had a serious reaction after receiving a immunization/vaccination?

- I have been provided the Vaccine Information Sheet (dated 07/24/08) and have no additional questions.
- I request that the vaccine be given to me.
- I hereby release all sponsors of the vaccination programs from any and all liability associated with the administration and potential side effects of the influenza vaccine.
- It is recommended that you remain at the administration site for 15 minutes after any injection in case of adverse reactions.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

***EHS PERSONNEL or DESIGNEE COMPLETE THIS SECTION***

**Injection Site:** \_\_\_L/Arm, \_\_\_R/Arm, \_\_\_Other    **Manufacturer:** Novartis    **Lot #:** 8803902    **Exp Date:** 05/31/09

Administering Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_