

Grossmont College Student Health Services 2008-2009 Influenza Vaccination Consent

All students/faculty with clinical assignments must comply with the new CA Senate Bill 739 (CA Health and Safety Code 1288.7), within two (2) weeks of 2008-2009 flu vaccine availability. (Note: This is the wording of the original document. Although the dates given are 2008-2009, the regulation continues to be in effect).

Please read the "Facts about Inactivated Influenza Vaccine" and answer the following questions. It is recommended you wait at least 30 minutes after the injection, due to the possibility of an allergic reaction.

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Is this the first "Flu" vaccination you have ever received? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had an allergic or serious reaction to the following; Flu vaccine, chicken eggs, or chicken products, Thimerosal, or have you had Guillain-Barre Syndrome (GBS)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you ill today? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you take blood thinners such as Aspirin, Clopidogrel (Plavix), Dipyridamole (Aggrenox), or Coumadin (Warfarin) on a daily basis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you under 18 years of age? <i>If you are under 18 years of age parental consent is required.</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you pregnant? If yes, you must provide written permission from your physician. | <input type="checkbox"/> | <input type="checkbox"/> |

Please check your appropriate age group:

Age: 6-18 19-49 50-59 60-64 Over 65

Please check your appropriate category: Student Faculty Department _____

ID #: _____ Date of Birth: _____ Telephone: _____

I have read the CDC 2008-9 Influenza vaccine information statement. By signing below I understand and consent to receive the vaccine.

Name: _____ Signature: _____ Date: _____
(Print)



Manufacturer: _____ Lot #: _____ Exp Date: _____

Route: IM Site: R Deltoid L Deltoid Seasonal Influenza Vaccine

Staff Signature _____ Date _____