Influenza Vaccine Consent Form `

KENT STATE UNIVERSITY | DeWeese Health Center

Name: _____ **KSU ID:** _____

Birth Date: _____ **Phone:** _____

I am a:	**Payment information:**
☐ Student ☐ Faculty/Staff ☐ Other: _____	☐ I have health insurance and I authorize DeWeese Health Center to bill my insurance for the influenza vaccine. ☐ I DO NOT have health insurance and understand there may be a charge for the influenza vaccine.

Health Insurance Information (if applicable)**:**

☐ I am the policy holder ☐ I have insurance under someone else, _____

☐ KSU Medical Mutual, Member ID #: _____

☐ Student Insurance through United Healthcare Student Resources, SRID #: _____

☐ Other insurance (fill in information on the card)

Insurance Carrier: _____ Group #: _____

Telephone #: _____ Member ID #: _____

Screening Questionnaire:	YES	NO
1. Do you currently have an acute illness with fever?		
2. Do you have an allergy to eggs or to a component of the vaccine?		
3. Have you ever had a serious reaction to influenza vaccine in the past		
4. Have you ever had Guillain-Barre syndrome?		

I have read or had explained to me the 2023-24 Vaccine Information Statement for the seasonal influenza vaccine and understand the risks and benefits. I consent to being vaccinated by KSU DeWeese Health Center staff and bill for services provided.

Patient Signature: _____ Date: _____

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For internal use only:

DATE:		Mfr	Lot #	Exp
☐ Fluarix ☐ Flulaval ☐ Other	Dose: 0.5cc Route: IM Site: ☐RD ☐LD			
	VACCINATOR:			