2020-2021 ADULT Influenza Vaccine Administration Record (VAR)

PATIENT ELIGIBILITY (*please check one)*

☐ Undergraduate Student	☐ Graduate Student/Assistant	☐ Faculty/Staff	☐ Retiree	☐ Spouse/Dependent (on a medical plan)

I. PATIENT INFORMATION

NAME: (Last) (First) (M.I.)		PUID:	
ADDRESS:	DATE OF BIRTH: (mm/dd/yyyy)	AGE:	SEX: ☐ Male ☐ Female
CITY: STATE: ZIP:	PHONE NUMBER:		
Policy Number: Group:	Insurance Carrier & Address on Card:		
Primary Insured Name and Date of Birth:	EMERGENCY CONTACT NAME & PHONE NUMBER:		

II. VACCINE SCREENING QUESTIONNAIRE

	YES	NO
Did you receive the seasonal influenza vaccine last year?		
Do you have a fever or are you feeling ill today?		
Do you have a serious allergy to eggs?		
Do you have other serious allergies? (If yes, please list):		
Have you ever had a serious reaction to a previous dose of flu vaccine?		
Have you ever had Guillain-Barré Syndrome within 6 weeks after receiving a flu vaccine?		

III. VACCINE CONSENT

I have read or had explained to me the Vaccine Information Statement and understand the risks and benefits of the vaccine(s) I have elected to receive. All of the questions I have about the risks and benefits have been answered to my satisfaction. I give consent to One to One Health, Purdue University Pharmacy, Purdue University Student Health, and their staff, certified student immunizers, and volunteers to administer the vaccination and bill my insurance, if applicable. I fully release and hold harmless Purdue University and any of its agents, officers, directors and employees, including certified student immunizers and volunteers from liability for any claims related to the administration of the vaccine. I understand that I have been advised to wait near the vaccination area for approximately 15 minutes to receive treatment in case of adverse reaction.

_____ _____

PATIENT/LEGAL GUARDIAN SIGNATURE DATE

OPTIONAL: Would you like us to notify your primary care provider that you received this vaccination? (If yes, please provide their information below)		☐ YES ☐ NO
Primary Care Provider Name:	Name of Practice:	Phone:
Address:	City: State: Zip:	Fax:

FOR ADMINISTRATIVE USE ONLY

VACCINE	ROUTE	DATE ADMINISTERED	VACCINE MANUFACTURER	LOT NUMBER & EXPIRATION DATE	VIS DATE
	Deltoid - IM L R	/ /			8/15/2019
VACCINE ADMINISTRATOR (Name & Title):					