

Last Name	First Name	MI	SLAC ID# (6 digits) OR SU/Student ID# (8-9 digits)	Date of Birth (mm/dd/yyyy)

I have an SHC/LPCH or Blood Center Badge

I am a physician in the School of Medicine

Please check the box which best describes you:

Primary University Affiliate	Spouse/Domestic Partner (*= \$32 charge)
<input type="checkbox"/> Stanford University Faculty / Staff / Employee	<input type="checkbox"/> of Stanford University Faculty / Staff / Employee*
<input type="checkbox"/> SLAC Employee	<input type="checkbox"/> of SLAC Employee*
<input type="checkbox"/> Part-time Casual or Temporary Employee	<input type="checkbox"/> of Part-time Casual or Temporary Employee*
<input type="checkbox"/> Postdoctoral Scholar / Fellow	<input type="checkbox"/> of Postdoctoral Scholar / Fellow*
<input type="checkbox"/> Undergraduate Student	<input type="checkbox"/> of Undergraduate Student (no charge)
<input type="checkbox"/> Graduate Student	<input type="checkbox"/> of Graduate Student (no charge)
<input type="checkbox"/> Medical Student	<input type="checkbox"/> of Medical Student (no charge)
<input type="checkbox"/> Retiree	<input type="checkbox"/> of Retiree*

Under which Stanford health insurance plan are you covered?

<input type="checkbox"/> Stanford Healthcare Alliance	<input type="checkbox"/> Kaiser Permanente	<input type="checkbox"/> Aetna EPO
<input type="checkbox"/> Cardinal Care	<input type="checkbox"/> Blue Shield / High Deductible	<input type="checkbox"/> Other / None

Please mark YES or NO for each answer.	YES	NO
1. Are you allergic to eggs?		
2. Have you had a serious (life-threatening) reaction to influenza vaccine in the past?		
3. Have you had a serious (life-threatening) reaction to hydrocortisone ¹ or gentamicin ¹ (antibiotic)?		
4. Do you have a history of Guillain-Barré Syndrome (causing temporary paralysis)?		
5. Are you ill today with a moderate to severe illness (with fever)?		

*If you answered "Yes" to questions 1-4, vaccine may be contraindicated. Please discuss with our staff, or speak to your personal physician.
If you answered "Yes" to question 5, you should postpone vaccination until you are feeling better.*

Patient Consent

I have read the Influenza [Vaccine Information Sheet \(VIS\)](#). I have had an opportunity to ask questions which were answered to my satisfaction. I believe I understand the benefits and risk of the influenza vaccine and request that it be given to me.

→ _____

Signature of person receiving the vaccine

_____ **Today's Date**

FOR ADMINISTRATIVE USE ONLY							
Seasonal Influenza Vaccine	VIS Date	Date of Vaccination	Dose and Route 0.5 ml IM		Vaccine Manufacturer	Lot Number	Expiration Date
	8/15/2019		<input type="checkbox"/> Left Deltoid	<input type="checkbox"/> Right Deltoid			
					<input type="checkbox"/> Fluarix Quad (GSK)	2SC23	6/30/2021
Vaccine Administrator (circle one) MD RN NP PA MA MS PCAP-S Student			S.Aguilar N.Iniguez M.Martinez C. Labson N. Molina-Ortega E. Davis R.Wittman R. Puri P. Fast C. Dekker N.Stoll Y.Rodrigues D.Hong M.Curry T. Cerone S. Rohlfses C. Song Other: _____ Signature: _____				