

BAYLOR SCOTT & WHITE HEALTH

INFLUENZA VACCINE CONSENT AND IMMUNIZATION RECORD

SCREENING QUESTIONS: If you answer "yes" to any of the questions, you may not be eligible for flu vaccine today.				Yes	No
1. Have you ever been diagnosed with severe muscle pains and paralysis (Guillain-Barre Syndrome) within 6 weeks after receiving a flu vaccine?					
2. Have you received a bone marrow transplant within the past 6 months?					
3. Have you had a serious allergic reaction to any vaccine including previous flu vaccines?					
4. Are you allergic to Thimerosal? If yes, you may still receive your influenza vaccination from a single-dose syringe. <i>Flu vaccines in multi-dose vials contain thimerosal to safeguard against contamination of the vial. Most single-dose vials and pre-filled syringes of the flu shot and the nasal spray flu vaccine do not contain a preservative because they are intended to be used once.</i>					
5. Have you already received a flu vaccination this season?					
PATIENT INFORMATION:					
Last Name:		First Name:		Middle Initial:	
Date of Birth:					
If under 18:					
Parent/Guardian Name:			Preferred Phone Number:		Relation to Patient:
DEMOGRAPHIC INFORMATION: If available and you have completed e-Check-In on MyBSWHealth, you do not need to complete the Demographic Information or Health Insurance Section.					
Gender: ☐ Male ☐ Female		Race: ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ Black or African American ☐ White			Ethnicity: Hispanic or Latino ☐ Yes ☐ No
SSN#: XXX - XX - _____					
Street Address:		City:		State:	Zip Code:
Preferred Phone Number:		Email Address:		Primary Care Physician:	
HEALTH INSURANCE:					
Insurance Company:		Group Number:		Policy Number:	Policy Holder Name:
Policy Holder DOB:					
☐ CHECK THIS BOX IF YOU DO NOT HAVE HEALTH INSURANCE COVERAGE OR ARE UNDERINSURED					
By signing below, I attest that all the answers above are true and correct to the best of my knowledge and all my questions have been answered.					
I have been provided the opportunity to read, been provided a copy, and/or declined a copy of the Vaccine Information Sheet ("VIS") for the influenza vaccine.					
I consent to receiving the influenza vaccine at this time and to allow BSWH to bill for the influenza vaccine.					
Signature:			Date:		Time:
Relation to Patient:					
For Vaccine Team Only: If completed electronically, this section may be left blank.					
Vaccine Manufacturer:		☐ GSK ☐ Sanofi ☐ Seqirus ☐ Other			Date/Time:
Vaccine Type:		Administered by:		Site:	
☐ Afluria (MDV) ☐ Afluria (syringe) ☐ Fluad (65+) ☐ Fluarix ☐ Flublok ☐ Flucelvax (MDV)		☐ Flucelvax (syringe) ☐ Flulaval ☐ Fluzone (MDV) ☐ Fluzone (syringe) ☐ Fluzone High Dose (65+)		☐ Right ☐ Left ☐ Deltoid ☐ Thigh	
Lot Number:		Location (Clinic/Facility):			
Expiration Date:		Dose: ☐ 0.5 mL ☐ 0.25 mL			
VIS Edition:		1/31/2025			

Scan doc type: Consent - Immunization

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