

DAVISON HEALTH CENTER
IMMUNIZATION ADMINISTRATION AND CONSENT FORM

First Name:	Last Name:
Campus Address:	City: <i>Middletown, CT 06459</i>
Date of Birth: ____/____/____ <small>Month/Day/ Year</small>	WesID#:

Payment Options:

- Undergraduate w/ Student Insurance
- Graduate student w/ Student Insurance
- Private Insurance \$40.00 (Billed to Student Account)
- Husky Insurance \$40.00 (Billed to Student Account)

HEALTH HISTORY

Is this your first flu shot?*	Yes ____	No ____
Have you ever had a severe allergic reaction to eggs or Thimerosal?	Yes ____	No ____
Are you sick with a fever or respiratory illness today?	Yes ____	No ____
Have you ever had a serious reaction to a flu shot or any vaccine?	Yes ____	No ____
If yes, describe: _____		
Do you have a history of Guillain-Barre Syndrome? (A kind of paralysis)	Yes ____	No ____
Have you had any other vaccinations in the past 4 weeks?	Yes ____	No ____
Are you pregnant?	Yes ____	No ____

*If this is your first flu shot ever, please plan to stay for 15 minutes after receiving vaccine for observation.

By signing this form: I give permission for the flu vaccine to be administered to me. I acknowledge that I have read the current Influenza Information Statement(s), have had questions answered to my satisfaction and understand the risks and benefits involved. On behalf of myself as well as my administrators and assigns, hereby release and forever discharge Wesleyan University and its trustees, employees and agents from any and all liability and/or obligation of any kind resulting from or in any way associated with the administration of this vaccine. I give my permission for Middlesex Hospital Homecare to release medical or other information necessary if I choose to file a claim to my insurance for the vaccination and to keep my signature on file. I agree to pay all charges that are not covered by insurance.

Signature of Recipient/Legal Representative: _____

Date: _____

For Clinic Use Only. Do Not Write Below This Line.

Vaccine:	Date Administered:	Injection Site: <small>Left or Right Arm</small>	Administered By:	Place Label Here:
Influenza		LA or RA		