Northeastern ILLINOIS UNIVERSITY
www.neiu.edu

Student Health and Counseling Services
5500 N. St. Louis Avenue
Chicago, IL 60625-4699

Health: 773-442-5800
Counseling: 773-442-4650

INFLUENZA (FLU) VACCINE CONSENT FORM

Name:_____ **NEIU ID#:** _____
LAST **FIRST**

	Please circle one:	
1. Do you have a sensitivity to latex?	Y	N
2. Are you allergic to chicken eggs or egg products?	Y	N
3. Are you allergic to Thimerosal (a preservative found in some cleaning products)?	Y	N
4. Are you exhibiting symptoms other than mild coughing, runny nose and/or diarrhea?	Y	N
5. Do you have a history of Guillan-Barre Syndrome or active neurological disorder?	Y	N
6. Have you ever had serious reaction after receiving the influenza and/or pneumonia vaccine?	Y	N
7. Are you currently receiving blood thinners such as Coumadin or Heparin?	Y	N
8. Have you received and read the Vaccine Information Statement?	Y	N

For Women

9. Are you pregnant or suspect you are pregnant?	Y	N

I verify that all information provided is true and hereby give consent to receive the Influenza Vaccine administered by NEIU Student Health Service.

Student Signature: _____ Date: _____

For Nurse Use Only:

Manufacturer/Lot No:_____ Exp. Date: _____ R / L Deltoid

Nurse's Signature: _____ Date: _____