Calvin University Health Services
Flu Immunization Consent Form

TODAY'S DATE: ____ / ____ / ______ **CALVIN ID (IF APPLICABLE):** ______________________

NAME (PRINT): __________________________________ **BIRTH DATE:** _________________ **AGE:** _____

HOME ADDRESS: ____

____

EMAIL ADDRESS: _______________________________ **PHONE NUMBER:** __________________________

CIRCLE ONE OF THE FOLLOWING:

CALVIN STUDENT *STAFF/FACULTY* *COMMUNITY MEMBER*

I AM CURRENTLY ENROLLED IN THE STUDENT HEALTH INSURANCE PLAN (SHIP)

YES **NO**

COMMERCIAL INSURANCE INFORMATION (OTHER THAN SHIP)

INSURANCE COMPANY NAME: ____

PRIMARY CARDHOLDER NAME: ____

POLICY/ACCOUNT/ID/CONTRACT/SUBSCRIBER #: ____________________**GROUP #:** __________________

PRIMARY CARDHOLDER BIRTHDATE: ____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

ARE YOU SICK TODAY?	***YES***	***NO***
DO YOU HAVE AN ALLERGY TO EGGS OR TO A COMPONENT OF THE VACCINE?	***YES***	***NO***
HAVE YOU EVER HAD A SERIOUS REACTION TO INFLUENZA VACCINE IN THE PAST?	***YES***	***NO***
HAVE YOU EVER HAD GUILLAIN-BARRE SYNDROME?	***YES***	***NO***

VACCINE INFORMATION (FOR OFFICE USE ONLY): {affix lot # label here} **L / R Deltoid**

ADMINISTRATOR SIGNATURE: ____

SCAN **ADD NEW**