BAYLOR SCOTT & WHITE HEALTH
INFLUENZA VACCINE 2023-2024 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. Do you have a serious allergy to eggs?		
2. Are you allergic to Thimerosal?		
3. Have you had a serious allergic reaction to any vaccine including previous flu vaccines?		
4. Do you have a history of Guillain-Barre Syndrome?		

PATIENT INFORMATION:			
Last Name:	First Name:	Middle Initial:	Date of Birth:
If under 18: Parent/Guardian:			
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 **SSN#:** XXX - XX - ___ ___ ___ ___	**Race:** ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ Black or African American ☐ White			**Ethnicity:** Hispanic or Latino ☐ Yes ☐ No
Street Address:	**City:**	**State:**	**Zip Code:**	**County:**
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:	☐ Afluria ☐ Fluad (high dose) ☐ Fluarix ☐ Flublok ☐ Flucelvax (egg-free) ☐ Flulaval ☐ Fluzone ☐ Fluzone High dose	Administered by:	
Lot Number:		Location (Clinic/Facility):	
Expiration Date:		Dose:	☐ 0.5 mL ☐ .25 mL ☐ .7 ml
VIS Edition:	8/6/2021	Site:	☐ Right ☐ Left ☐ Deltoid ☐ Thigh

Scan doc type: Consent - Immunization

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