

**McCormick and Co. Inc. Health & Wellness Center
FLU VACCINE ADMINISTRATION CONSENT**

Please answer these questions by checking the appropriate answer. If the question is not clear, please ask the staff member to provide you additional information.

	YES	NO	Don't Know
Are you sick today or have you recently been sick?			
Do you have any allergies to medications, eggs, any vaccine or vaccine component?			
Have you ever had a serious reaction to any vaccine?			
Women Only: Are you pregnant			
Do you have any questions or concerns about the vaccine you are going to receive today?			
Have you read the Vaccine Information Statement (VIS)?			

I have read or have had explained to me the information in the VIS statement about the vaccine I am going to receive today. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine listed below and ask that the vaccine be given to me today.

PRINT EMPLOYEE NAME: _____ **PAYROLL:** _____

Employee Signature: _____ **Date:** _____

HEALTH & WELLNESS CENTER USE ONLY

	VACCINE
Vaccine Given	FLUZONE Quadrivalent Influenza Vaccine – Prefilled – 20-21
Date Given	
Manufacturer	Sanofi Pasteur
Lot Number	
Expiration Date	06/30/2021
Site of Injection	RT LT Deltoid
VIS COPY GIVEN	Yes 8/15/19

Staff Administering Vaccine Signature
H&W VACC ADM 11-2019

Date