



# University POD Client Consent Form



Please print neatly in capital letters as shown in the example:

EXAMPLE 123

Please shade circles

Correct: ● Incorrect ☒ ☑

**Personal Information:** Provide information as completely as you can. All information will be kept confidential.

Last Name										First Name										MI	
Street Number										Street Name										Apt. Number	
City												Zipcode									
Area Code			Phone Number				Date of Birth (MM/DD/YYYY)				Race/Ethnicity:										
Mother's First Name										Gender		<input type="radio"/> Asian <input type="radio"/> Black/African American <input type="radio"/> Hispanic/Latino <input type="radio"/> White <input type="radio"/> Native Hawaiian/Pacific Islander <input type="radio"/> American Indian/Alaskan Native <input type="radio"/> Other									
REQUIRED: Have you reviewed the CAIR disclosure form?										<input type="radio"/> YES <input type="radio"/> NO											

### Medical Screening

1. Do you have a fever or are you sick today?	<input type="radio"/> YES	<input type="radio"/> NO
2. Are you pregnant, or do you think you may be pregnant?	<input type="radio"/> YES	<input type="radio"/> NO
3. Have you had a serious reaction to flu vaccine requiring medical help?	<input type="radio"/> YES	<input type="radio"/> NO
4. Do you have a severe allergy to eggs?	<input type="radio"/> YES	<input type="radio"/> NO
5. Do you have an allergy to thimerosal?	<input type="radio"/> YES	<input type="radio"/> NO
6. Do you have an allergy to latex?	<input type="radio"/> YES	<input type="radio"/> NO
7. Have you ever had Guillain-Barre Syndrome (GBS)?	<input type="radio"/> YES	<input type="radio"/> NO
8. Have you received any of these vaccines in the last 4 weeks? [MMR, Varicella, LAIV, Shingles]	<input type="radio"/> YES	<input type="radio"/> NO
9. Do you have any of the following Medical Conditions? [Heart, Lung, Kidney, or Liver Disease; Asthma; Cancer; Metabolic disease (i.e. diabetes); Blood Disorders (i.e. leukemia, lymphoma, sickle cell disease); Immune System Disorder (i.e. HIV/AIDS, steroid therapy)]	<input type="radio"/> YES	<input type="radio"/> NO
10. IF the child is <5 years, have they been diagnosed with wheezing in the last 12 months?	<input type="radio"/> YES	<input type="radio"/> NO
11. Is the child taking long term medicine therapy containing ASPIRIN?	<input type="radio"/> YES	<input type="radio"/> NO
12. For Persons Under 19 select VFC eligibility: <input type="radio"/> Uninsured <input type="radio"/> Medi-Cal/CHDP <input type="radio"/> American Indian/Alaskan Native <input type="radio"/> Not VFC Eligible		

I CONSENT TO THE VACCINATION PROVIDED.	If under 18 years of age, PRINT name of parent or legal guardian
Signature	

**STOP - DO NOT WRITE BELOW THIS LINE**

Screener:

Is the person being vaccinated between 2-49 years old? (Verify Age)*							<input type="radio"/> YES	<input type="radio"/> NO
Admin. by	Dose #	Flu Vaccine	Site	Manufacturer	Dosage	Lot Number		
<input type="checkbox"/>	<input type="radio"/> 1	<input type="radio"/> Live (Nasal Spray) VIS 7/2/2012	Intranasal	MedImmune	0.2 mL	AJ2158		
Date Administered	<input type="radio"/> 2	<input type="radio"/> Inactivated (.5) VIS 7/2/2012	<input type="radio"/> LD <input type="radio"/> RD <input type="radio"/> LT <input type="radio"/> RT	Merck/CSL	0.5 mL	P51108		
1 1 / 0 8 / 2 0 1 2								
M M / D D / Y Y Y Y								