TriHealth
Occupational Medicine Services

Bethesda Care Arrow Springs
Phone: 513-282-7075
Fax: 513-282-7076

Bethesda Care Butler County
Phone: 513-874-3990
Fax: 513-860-5071

Bethesda Care Eastgate
Phone: 513-752-3695
Fax: 513-752-3039

Bethesda Care Norwood
Phone: 513-731-3399
Fax: 513-731-2882

Bethesda Care Queensgate
Phone: 513-241-4135
Fax: 513-241-6510

Bethesda Care Sharonville
Phone: 513-563-1505
Fax: 513-769-4776

Good Samaritan
Phone: 513-862-2875
Fax: 513-862-2860

REQUEST FOR FLU VACCINE 2009/2010

If you have any of the following conditions, we will not be able to provide immunization.

YES	NO	
		Allergy to chicken eggs or protein, or a history of allergic reaction to flu vaccines in the past.
		Allergy to any vaccine component including thimerosal (mercury), neomycin, polymyxin, formaldehyde, betapropiolactone or deoxycholate.
		History of Guillian-Barre Syndrome, any active neurological disorder, or a history of neurological symptoms after flu vaccines in the past.
		Current illness with fever.

My signature on this form indicates that I understand all of this information and that I have none of the above conditions. I have received and read the 8/11/09 VIS (vaccine information sheet) concerning the Influenza vaccine. I have had an opportunity to ask any questions concerning this vaccine and they have been answered to my satisfaction. I accept the risk of possible side effects and I request that the vaccine be given to me.

Participant's Signature: _____ Date: _____

Witness: _____

PLEASE PRINT & FILL OUT COMPLETELY

_____ _____ _____
Last Name First Name Middle Initial

DOB: _____-_____-_____ Sex: ❒ M ❒ F

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Employer: _____ Employer Location: _____

*** PLEASE REMAIN ON-SITE 15 MINUTES AFTER INJECTION ***

Medical Staff Notes: Influenza Virus Vaccine, U.S.P. Trivalent Types A & B. This year's influenza vaccine contains two type A viral strains and one type B viral strain that the CDC feels will represent the influenza viruses believed likely to circulate in the upcoming flu season 2009/2010.

0.5 ml IM deltoid: ❒ RT ❒ LT Exp. Date: 6/30/2010

❒ Tolerated well; no reaction during 15-minute observation period. ❒ Reaction occurred

Manufacturer: _____ Lot #: _____

Comments: _____

Given by: _____ Date: _____ Time: _____

[Amount Paid: $_____ Received by: _____]