665 Bay Road. Unit D, Dover, DE 19901
phone (302) 678-1303 fax (302) 310-8851

800 N. DuPont Blvd, Milford, DE 19963
phone (302) 430-5705 fax (302) 310-8851

18383 Hudson Rd, Milton, DE 19968
phone (302) 684-3812 fax (302) 310-8851

Patient Label

COMPANY FLU VACCINATION CONSENT FOR 2025-2026 SEASON

Bayhealth is offering flu vaccinations this fall. The vaccination has been standardized to the United States Public Health Service requirements. The trivalent formulation of cell- or recombinant-based influenza vaccines for the 2025-2026 U.S. influenza season contain the following: an A/Wisconsin/67/2022 (H1N1) pdm09-like virus; an A/District of Columbia/27/2023 (H3N2)-like virus; and a B/Austria/1359417/2021 (B/Victoria lineage)-like virus. Center for Disease Control and Prevention (CDC) recommends flu vaccinations for all persons age 6 months and older. It is even considered more important for certain individuals (e.g. healthcare workers, persons with morbidities, pregnant individuals, others) to be immunized against influenza each year.

WARNING: This vaccine should not be given to:

- ★ Anyone with a history of serious hypersensitivity (*allergy*) to latex (***a latex-free vaccine is available***)
- ★ Anyone with a severe illness
- ★ Anyone with a history of severe reaction to the flu shot or any other injectable medication in the past
- ★ Anyone with a prior history of Guillain-Barre Syndrome (*a severe paralytic illness*)
- ★ Anyone with a fever of 100.4° or greater should wait to be vaccinated until the fever subsides

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Printed Name: _____ **Date of birth:** _____/_____/_____

Name of Company: _____ **Employee Number:** _____

I acknowledge that I have received information about influenza and the risks and benefits of the vaccination. I have read all the warnings above, have received a copy of the CDC's Vaccination Information Statement (VIS). I have had the opportunity to ask questions and if asked, my questions have been answered to my satisfaction. I have been advised that if I have any question at all about this vaccination or my ability to receive it, I should not receive the vaccination today, but should first consult with my physician.

☐ **ACCEPT** - I understand that my signature below indicates that I accept the recommended influenza vaccination.

Patient's signature: _____ **Date:** _____/_____/_____

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Manufacturer: ☐ GSK ☐ Sanofi Pasteur ☐ bioCSL ☐ Protein Sciences ☐ Seqirus ☐ CSL Behring

Expiration date: _____/_____/_____ **Lot number:** _____

Brand: _____ ☐ Flucelvax ☐ Fluarix ☐ Flualval ☐ Fluzone

Injection site: ☐ Right deltoid ☐ Left deltoid

Administered by:_____ **Date:** _____/_____/_____ Time: _____