Holy Name
ASIAN HEALTH
SERVICES

Holy Name Medical Center
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# INFLUENZA (FLU) VACCINATION CONSENT FORM
## 流感 (FLU) 疫苗同意书

**For Clinical Use Only**

Name: (姓名) _____
(First Name) 名 (Last Name) 姓

Street Address 地址 :_____

City 城市 _____State 州_____Zip code邮政编码_____

Phone Number(电话): _____

Date of Birth (出生日期): _____ ❑ Male(男) or ❑ Female(女)

**For Clinical Use Only 医务人员填写**

Date of Vaccination: 10/22/2023
Dosage -
Manufacturer: Afluria
Expiration Date: 05/31/2024
Lot #: AU1061D
Site of Injection: Deltoid L R
Signature of Vaccinator:

_____

**PLEASE ANSWER THE FOLLOWING:**

1. Are you sick today? Yes 是 / No 否
   你今天是否不适?
2. Do you have allergies to medications, food, vaccine component, or latex? Yes 有 / No 没有
   你对药物、食物、疫苗或乳胶过敏吗？？
3. Have you ever had a serious reaction after receiving a vaccination? Yes 有 / No 没有
   你曾经对疫苗出现过严重的反应吗?
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? Yes 有 / No 没有
   你是否有以下的长期健康问题心脏病、肺病、哮喘、肾病、代谢综合征（例如糖尿病）、贫血或其他血液疾病?
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? Yes 有 / No没有
   你是否患有癌症、白血病、艾滋病毒/艾滋病或任何其他免疫系统问题?

6. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of Rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments? Yes 有 / No没有
在过去 3 个月中，你是否服用过影响免疫系统的药物，例如Prednisone、其他类固醇或抗癌药物；接受类风湿性关节炎、 克罗恩病或银屑病(乾癬) 治疗或药物；或者接受过放射治疗吗?

7. Have you had a seizure, a brain, or other nervous system problem? Yes 有 / No没有
你是否患曾经有癫痫、大脑或其他神经系统问题?

8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? Yes 有 / No没有
在过去的一年中，你是否接受过输血或血液制品，或接受过免疫（丙种）球蛋白或抗病毒药物?

9. For women: Are you pregnant or is there a chance you could become pregnant during the next month? Yes 有 / No没有
女士：你是否怀孕了或者你是否有可能在下个月期间怀孕？？

10. Have you received any vaccinations in the past 4 weeks? Yes 有 / No没有
你在过去 4 周内接受过任何疫苗吗?

I confirm that I am (i) the patient and 18 years of age or older; (ii) the parent or legal guardian of the minor patient; or (iii) the legal guardian of the patient. I give consent to Holy Name to administer the vaccine(s) I have requested. I have read the Vaccine Information Statements and/or had the statements explained to me. I understand the risk and benefit related to the vaccines I will receive. I have asked any questions I had and they have been answered. I have been told and I understand that I should remain near Holy Name vaccination site for at least 15 minutes after administration for observation.
本人声明我是 (i) 已年满 18 岁的患者； (ii) 未成年患者的父母或法定监护人； (iii) 患者的法定监护人。我同意圣名为我接种以上疫苗。我已阅读疫苗信息声明和/或已向我解释了这些声明。我了解接受的疫苗相关的风险和益处。我已经提出了所有问题并且已得到解答。本人已被告知并且明白，在接种疫苗后我应该至少应留观 15 分钟。

PATIENT OR PARENT/LEGAL GUARDIAN SIGNATURE: _____ DATE 日期: _____
(患者或家长/法定监护人签名)

RELATIONSHIP TO PATIENT: _____
(与患者的关系)