



INFLUENZA VACCINE (FLU SHOT) CONSENT FORM

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|---|------------------|
| 1. Have you ever had an allergic reaction to flu vaccine? | Yes or No |
| If yes, please describe type of reaction: _____ | |
| 2. Do you have a history of Guillain-Barre Syndrome (GBS)?
(GBS is illness associated with the swine flu in 1976 characterized by fever, nerve damage, and muscle weakness) | Yes or No |
| 3. Are you allergic to Thimerosal (a mercury based preservative), Formaldehyde, or polyethylene glycol? | Yes or No |
| 4. Are you allergic to latex? | Yes or No |
| 5. Are you currently ill, you have a fever greater than 101°, URI? | Yes or No |
| 6. Are you currently taking Coumadin, Theophylline, or Dilantin? | Yes or No |
| 7. If you are female, are you pregnant? # Weeks _____ | Yes or No |

I hereby certify that the foregoing history is true and complete to the best of my knowledge and I have received and read the "Vaccine Information Statement" from the CDC, have had an opportunity to ask questions that were answered to my satisfaction, and do wish to receive the flu vaccination fully understanding the risks and the benefits. I understand the adverse reactions associated with the Influenza vaccine. I believe that the benefits outweigh the risks and I assume full responsibility for any reactions that may result. I waive and release any and all claims I, or anyone claiming by or through me, now have or may hereafter acquire against the clinic site, and their respective parent, subsidiaries, and affiliates, and each of their directors, officers, employees, and agents for any and all damages or injuries arising out of or related to the receipt of the immunization, including, without limitation, if I, the person named below for whom I am authorized to make this request, contract influenza, other respiratory diseases, or suffer any other damages or adverse reactions, including death, following administration of this immunization. I am requesting that the immunization be given to me or the person named below for whom I am legal guardian. **The flu shot is considered safe for pregnant women, breastfeeding women and their infants and is recommended for women who will be pregnant during the flu season since they are at increased risk for flu-related complications.**

PARTICIPANT INFORMATION AND CONSENT

LAST NAME:	FIRST NAME:	MI:
ADDRESS:	CITY:	STATE: ZIP:
PHONE:	E-MAIL:	
BIRTHDATE:	AGE:	
SIGNATURE:		DATE:

FOR CLINIC USE ONLY

MANUFACTURER AND LOT#:	LOT #
EXPIRATION DATE:	
SITE OF INJECTION:	R / L DELTOID
SIGNATURE AND TITLE OF VACCINE ADMINISTRATOR:	
DATE VACCINATED:	