



Influenza Immunization Consent Form

First Name: [] Middle Initial: []
Last Name: []
Birthdate: [] Age: [] Sex(M/F) []

- Please check YES or NO for each question...
1. Are you allergic to eggs...
2. Do you have a history of Guillain-Barré Syndrome...
3. Have you ever had a serious reaction...
4. Do you have a fever, diarrhea, or vomiting today?
5. For Women: Are you pregnant or suspect you are pregnant?

CHECK WITH YOUR PHYSICIAN AND/OR YOUR HEALTHCARE PROVIDER BEFORE RECEIVING THIS VACCINE IF YOU CHECKED "YES" ON ANY OF THE ABOVE QUESTIONS.

PARTICIPANTS WHO SHOULD NOT TAKE THE VACCINE:

- Persons with an allergy to eggs or to Thimerosal...
Those with a history of a serious reaction to a previous flu shot.
Anyone who has ever been paralyzed with Guillain-Barré Syndrome (GBS)...
Pregnant women during the first 3 months of pregnancy...
Persons who are ill and have a fever...

POSSIBLE SIDE EFFECTS FROM THE VACCINE:

Most people have no side effects from influenza vaccines. Flu shots are given by injection into a muscle of the upper arm. This may cause soreness for a day or two at the injection site and occasionally may also cause a fever or aches for one or two days.

THE VACCINE SHOT SHOULD NOT BE ADMINISTERED TO PEOPLE WITH ACUTE FEBRILE ILLNESS UNTIL THEIR TEMPORARY SYMPTOMS HAVE ABATED. HOWEVER, MINOR ILLNESSES WITH OR WITHOUT FEVER SHOULD NOT CONTRAINDICATE THE USE OF INFLUENZA VACCINE, PARTICULARLY AMONG CHILDREN WITH MILD RESPIRATORY TRACT INFECTION OR ALLERGIC RHINITIS. CONTRAINDICATIONS: INFLUENZA VIRUS IS PROPAGATED IN EGGS FOR THE PREPARATION OF INFLUENZA VIRUS VACCINE; THUS, THIS VACCINE SHOULD NOT BE ADMINISTERED TO ANYONE WITH A HISTORY OF HYPERSENSITIVITY TO ANY COMPONENT OF THE VACCINE INCLUDING THIMEROSAL.

WARNING: PLEASE CHECK WITH YOUR PHYSICIAN BEFORE TAKING THE VACCINE.

CONSENT FOR SERVICES, MEDICAL RECORDS & HIPPA PRIVACY INFORMATION

I hereby acknowledge full and complete consent to and make request for an influenza vaccination. I am physically able to have this vaccine and have never had an adverse reaction to an influenza vaccine. I hereby request and authorize The Wellness Group, LLC's designated subcontractor who is an independent nurse/healthcare staffing agency, not directly affiliated with The Wellness Group, LLC, to administer this vaccine to me or the person named above for whom I am the legal guardian.

Signature of Recipient or Legal Guardian Signature Date of Service

Vaccine Information (Nurse Use Only)

Table with 4 columns: MFR, Lot#, Exp. Date, Dosage Amount.
Rows: IM Route, Left Deltoid, Right Deltoid, Admin. Date.
Bottom row: Nurse Signature, Name of Company where Clinic is Located.