crossover HEALTH

Influenza Vaccination Consent Form 2017 - 2018

Crossover Health Medical Group

Flu Vaccine Questionnaire

1. Are you allergic to eggs or egg products?	Yes	No
2. Are you allergic to thimerosal (a preservative found in certain vaccinations, eye contact lens solution, etc)?	Yes	No
3. Have you ever had a severe allergic reaction to the flu vaccine or other vaccines?	Yes	No
4. Are you allergic to latex?	Yes	No
5. Are you currently sick (does not include minor illnesses)?	Yes	No
6. Do you have a history of Guillain-Barre Syndrome?	Yes	No
7. Is there a chance you may be pregnant?	Yes	No

I have read, or had explained to me, the Vaccine Information Statement about influenza vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the influenza vaccination be given to me. I authorize the release of information obtained by this consent for Crossover Health treatment, payment, operations or for other public health purpose.

Patient Name _____ **DOB** _____

Signature _____ **Date** _____

FOR OFFICE USE:			
Lot#		**Injection Site**	R or L Deltoid
Exp		**Date**	
Manufacturer		**Provider**	