Influenza Vaccine Consent Form

2140 Peachtree Road; Atlanta, GA 30309 678-805-7425

www.urgentcareatpeachtree.com Fax # 678-550-6509

Name: ______________________ Date of Birth: ______________ Age: __________

Address: ______________________ Email: ______________ Telephone: __________

City: __________ State: __________ Zip Code: ______________ Apt# __________

Before consenting to receiving the influenza vaccination:

- Please read the "Influenza Information Sheet" provided to you prior to your vaccination
- Please Read the questions below; if you answer YES to any of the questions, please discuss with your immunization provider
- The information you provide is private and confidential and will not be used for any other purpose

Questions for discussion: (Please check appropriate boxes)	Yes	No
1. Do you have an acute fever or illness at present?		
2. Have you been vaccinated against the flu in previous years?		
3. Have you experienced any significant problems after vaccination?		
4. Are you allergic to eggs or chicken feathers or thimerosal (Mercury-based preservative)?		
5. Are you allergic to neomycin, polymyxin or gentamincin or Latex?		
6. Are you taking any cortisone, steroid, immunosuppressive medicine or theophylline, warfarin, Dilantin?		
7. Have you ever had Guillian-Barre Syndrome?		
If Yes, please specify		
8. Have you ever fainted when given an injection?		
9. **FOR WOMEN**: Are you pregnant or breast-feeding?		

MEDICARE PART B: Identification Number: ______________________

Do you have a Secondary Insurance carrier? Yes No (please circle)

If YES: Insurance Carrier Name: ______________________

Member ID: ______________ Group Number: ______________

Consent:

☐ I have read and understood the influenza information sheet about the risk of the influenza vaccination including the risks of not being vaccinated

☐ I have been given the opportunity to discuss the risks and benefits with my immunization provider

☐ I consent to receiving the influenza vaccine injection and inclusion on clinic database

☐ Furthermore, I hereby release and forever discharge myself, my heirs, executors, administrators and assignees, Urgent Care at Peachtree and their employees, owners and representatives as well as any company sponsoring this event and demands, actions and causes of action, which may result from participation in this program.

☐ I understand that consent can be withdrawn at any time prior to vaccination

Patient / Parent / Guardian Signature:______________________________**Date:**__________

For Office Use Only	**For Office Use Only**
Date Given:	Manufacturer:
Lot Number:	Exp. Date:
Site-Deltoid (Check one: L ☐ R ☐	Influenza Vaccine given by:
Provider Signature:	