

Influenza Vaccine Consent and Release Form

PLEASE PRINT LEGIBLY

First Name: _____ Last Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____ Phone number: _____

Insurance Provider: _____ Member ID Number: _____

Please read each question and check yes or no to each question

Yes ____ No ____	Are you under the age of 18
Yes ____ No ____	Are you allergic to eggs, egg products, or Thimerosal (Mercury derivative used as a preservative)
Yes ____ No ____	Are you pregnant or nursing
Yes ____ No ____	First time having a flu shot (if so, you must sit with the nurse for 15 minutes)
Yes ____ No ____	Has your doctor told you that you have Guillain-Barre Syndrome (a rare, severe autoimmune disorder)
Yes ____ No ____	Have you ever had a reaction to a flu vaccine (tightening in your throat, inability to breathe)
Yes ____ No ____	Currently Ill (fever, acute respiratory or other active infection or illness)

Consent for Vaccination

I understand that common side effects of the flu vaccine can include soreness, fever, chills, and headaches or muscle aches, which typically last 24-48 hours. I release Integrated Corporate Health (Integrated Health 21) and its affiliates from liability for any reaction and will seek medical care if severe symptoms occur. I confirm I have no conditions listed above that would prevent me from receiving the flu vaccine. I have read or have been informed of the CDC's Vaccine Information Statement and understand the risks and benefits and consent to receiving the flu vaccine.

I request that payment of authorized Medicare/ other insurance benefits be made on my behalf to Integrated Health 21 for any services furnished to me by my supplier. I authorize the release of my medical information to the Centers for Medicare and Medicaid Services and/ or my insurance company and its agents; any information needed to determine these benefits/ benefits payables for related services. I am responsible for all charges, regardless of insurance status, as well as copayments and deductibles.

Signature _____

Date _____

Company Name: _____

Nurse Only: Complete all fields legibly

Dose	Injection Site (Please Circle)	Vaccination Type- Place check mark next to serum used	Lot Number	Expiration Date	Nurse Signature/ Date
0.5 mL	Right	Flulaval (PF SYR) _____			
		Flucelvax (PF SYR) _____			
	Left	Fluzone (PF SYR) _____			
		Fluarix (PF SYR) _____			
		FluAd (HD 65+) _____			