

Influenza Vaccine Consent & Release

All products used to administer the flu vaccine are latex free.

Nursing staff only TF _____ HD _____ Temperature: _____
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Please read carefully and answer all the following questions accurately. Be sure to ask your nurse any questions prior to receiving the vaccine.	YES	NO
1. Are you allergic to eggs?		
2. Have you ever had a serious reaction such as itching, hives, and swelling, shortness of breath or difficulty following the administration of the flu vaccine?		
3. Have you ever been diagnosed with or paralyzed by Guillain -Barre' Syndrome or any Neuro-Muscular disease?		
4. Are you presently suffering from a moderate or severe illness?		
5. Do you have a fever at the present time?		
6. Are you pregnant or currently nursing a baby?		
7. Are you allergic to Thimerosal (a preservative found in some contact solutions)?		
8. Is this your first flu shot EVER ?		

Address: _____

Date of birth: _____

Phone number: _____

Administration of this vaccine is governed by the recommendations of the Center for Disease Control (CDC). Please read the vaccination information statement or (VIS) prior to receiving your vaccine. You can locate a duplicate of this VIS form and other important vaccine information at: <http://www.cdc.gov/vaccines/hcp/vis/vis-statement.flu.pdf>.

1. If you have answered yes to any of the questions above, notify your nurse on the day of your scheduled vaccination. You may be requested to consult your health care provider before receiving a vaccination.
2. This vaccine does NOT protect you from COVID-19.
3. If you have a temperature greater than or equal to 100.0 degrees Fahrenheit or do not feel well on the day of your scheduled vaccination, you will NOT receive a flu shot and may be requested to return on another day.
4. If you have ever had a severe allergic reaction to a flu shot in the past or have had a serious allergy to any part of this vaccine, you will not receive the flu shot.
5. Most but not all vaccine contains a small amount of egg protein.
6. If you ever had Guillain-Barre' Syndrome (also called GBS) you will not receive a vaccination.
7. If you are pregnant or nursing, you will be offered a preservative-free (Thimerosal Free) flu shot. If you are pregnant or think you may be pregnant, you will be required to present a note from your doctor to the nurse on the day of the clinic prior to receiving your vaccine.
8. If this is the first time you have ever had a flu shot, you MUST remain in the room with the nurse for a period of 10 minutes for observation. If you cannot stay, you will not receive a vaccination and may be requested to return on a day in which you can remain onsite.
9. It takes about 2 weeks for protection to develop after vaccination.

Consent & Release

Waiver and Release: I for myself and heirs, executors, administrators, and assigns do hereby forever release and discharge and hold harmless, 360 Medical Consulting, LLC and respective officers, directors, shareholders, employees contractors, agents, representatives, affiliates and assigns and successors in interest (herein collectively referred to a "Releases") from any and all causes of action, suits, claims, damages, judgements, and demands of any nature whatsoever, in law, admiralty or equity, which I may not or hereafter have as a result of my participation in this vaccination program and my receipt of a flu shot (including without limitation and bodily injury, illness or death). I further understand that in the event any cause or other provision of this release shall be found to be unenforceable or invalid by any court of competent jurisdiction that the remaining provisions of this release shall continue to remain in force and effect.

Consent: I further acknowledge and fully understand the terms of this consent and release form and am signing the same of my own free will without any duress of any nature. I have read the above information and have answered all the questions above accurately and to the best of my knowledge. I have received, read, and I fully understand the CDC vaccine information sheet (VIS) provided that explains both the benefits and risks of a vaccine. I have reviewed the contraindication information above. I have answered all the questions above truthfully and have asked any questions I have prior to receiving a vaccination. I understand it is my responsibility to discuss with my primary care physician before signing this consent and administration. All my questions have been answered regarding the influenza vaccine. I deny any current illness or medical history as indicated above. I understand that the decision to have an influenza (flu) vaccination is mine and mine alone. I hereby agree to indemnify and hold harmless 360 Medical Consulting and/ or any of their affiliated or related entities from any claims, fees, penalties, fines, or other damages incurred as a result of any false statements made by me on this form.

Printed Name: _____ Signature: _____ Vaccination date: _____

Nursing Staff Only

- Lot# _____ Dose: _____ Manufacturer: _____ Exp. Date: _____
- Lot# _____ Dose: _____ Manufacturer: _____ Exp. Date: _____
- Preservative-Free: Lot#: UT8408LA Dose: 0.5ml Manufacturer: Sanofi Pasteur Exp. Date: 06/2025
- (65yrs.>)** Preservative-Free. Lot# U8429CA Dose: 0.7ml Manufacturer: Sanofi Pasteur Exp. Date: 06/2025
- High Dose (18yrs>)** Preservative Free Lot# _____ Dose: _____ Manufacturer: _____ Exp. Date: _____

Administration Site: (Check One) Left _____ Right _____ Upper Arm _____ Administered By: **Naviot Kaur/ Angie Wu/ Alicia Wright/ Rainier Chirinos/ Lea Tesfahun**

Date: _____