Informed Consent for Adult Immunization/Flu Vaccination

PLEASE ANSWER THE FOLLOWING QUESTIONS: The following questions will help us determine which vaccines you may be given today. If you answer 'yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

Question	Answer
1.Do you currently have an active (acute) respiratory or other infection, or have you had elevated temperature in the last 48 hours?	Yes / No
2. Have you ever had a serious reaction after receiving a vaccination?	Yes / No
3. Have you ever had a flu shot before?	Yes / No
4. Do you have allergies to medications, food, eggs, chicken feathers, or Thimerosal (in contact lens solutions) that causes swelling, hives, or shortness of breath?	Yes / No
5. Do you have a long-term health problem with heart disease, lung disease, Asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorders?	Yes / No
6. Do you have cancer, leukemia, AIDS, or any other immune system problem?	Yes/ No
7. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had any radiation or chemotherapy treatments?	Yes / No
8. Have you had a seizure, brain, or other nervous system or neurological disorder or do you have a pending splenectomy?	Yes / No
9. During the past year, have you received a transfusion of blood or blood products, or been give immune (gamma) globulin or antiviral drug?	Yes / No
10. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	Yes / No
11. Have you received any vaccinations in the past 2 weeks, (if so, which arm left or right)	Yes / No
12. Have you ever had Guillain-Barre Syndrome?	Yes / No

I accept that services might be rendered in a non-private setting. I authorize for my immunization records to be disclosed to my employer, the county, state, or to any other governmental entity as may be required. I understand and accept the possible side effects of the vaccine(s) which include, but are not limited to tenderness, redness, swelling of the injection site with associated arm discomfort, and/or fever, weakness, headache, and muscle aches for 1-2 days. Less likely reactions may be fainting, allergic, anaphylactic, and neurological reactions. I have spoken with a nurse and asked questions to my satisfaction. I agree that Discovery Health Services, shall have no responsibility or liability and shall be held harmless if I contract any illness or suffer adverse reaction of any kind following the administration of the vaccine/or vaccines. I have been informed that (barring any known allergies) two acetaminophen tablets may be taken every 4-6 hours as needed for discomfort. If symptoms persist or fever is 101 degrees or higher, I will consult a physician. I hereby consent to the administration of said vaccinations.
I have read the above statement and been given a copy of the CDC Vaccine information guide (titled: "What You Need to Know"). I understand all the terms and conditions as outlined above, and further agree by affixing my signature below that I shall not hold liable Discovery Health Services for any harm that may be caused by my receiving a vaccine/s, and waive any claim for damages that I (or anyone on my behalf) may have against Discovery Health Services, its directors, employees , or agents on account of any misfortune or injury I may suffer because of the vaccination/s.

Information about person to receive vaccine:		
Last Name:	**First Name:**	**MI:**
Address:		
City:	**State:**	**Zip:**
DOB:	**Age:**	
Signature:	**Date:**	

FOR NURSE USE ONLY	
VACCINE MANUFACTURER:	
LOT #:	**EXPIRATION DATE:**
0.5 ml 1.0 ml	**DELTOID: RIGHT LEFT**
VIS RECEIVED: YES NO	
DATE:	**VACCINE GIVEN BY:**

FOR NURSE USE ONLY	
VACCINE MANUFACTURER:	
LOT #:	**EXPIRATION DATE:**
0.5 ml 1.0 ml	**DELTOID: RIGHT LEFT**
VIS RECEIVED: YES NO	
DATE:	**VACCINE GIVEN BY:**