INFLUENZA (INACTIVATED) VACCINE CONSENT FORM

Last Name ____ First Name ________________________________ Sex: ☐ Male ☐ Female

Address ____ City _______________________ State __________ Zip ________

Date of Birth ______________Phone # _________________________ Physician ____

Not all individuals requesting the flu vaccine can safely be immunized against influenza. Consult with your physician to obtain flu vaccine if one or more of the following is true:

1. Have you ever had a severe reaction to a previous influenza or other vaccine? ☐ Yes ☐ No
2. Are you allergic to eggs, chicken feathers, chicken or chicken dander? ☐ Yes ☐ No
3. Are you allergic to Thimerosal (a mercury derivative found in contact lens solution and Merthiolate)? ☐ Yes ☐ No
4. Are you Allergic to Latex? ☐ Yes ☐ No
5. Do you have a fever or active illness? ☐ Yes ☐ No
6. Are you pregnant? ☐ Yes ☐ No
7. Do you have a past history of Guillain-Barre Syndrome? ☐ Yes ☐ No
8. Are you under the age of eighteen (18)? ☐ Yes ☐ No
9. Are you currently receiving blood thinners such as coumadin, aspirin or heparin? ☐ Yes ☐ No

Having received an explanation and informed consent, I hereby agree to release and hold Hemmingsen Drug Store, its employees, agents and representatives harmless from further responsibility with regard to my receiving the injections.

Influenza vaccine is composed of dead influenza viruses and will not give you the flu. It is given by injection. As with any medication, there are risks and possible side effects/reactions. Side effects of influenza vaccine are generally mild in adults and occur within 6-12 hours after vaccination and can persist for one or two days. These reactions consist of soreness of the injection site, fever, chills, muscular aches, and in rare cases, even death. If you should have a reaction, you should CONTACT YOUR PHYSICIAN, and Hemmingsen Drug Store pharmacist (269) 781-3411.

I have received and read the MI/CDC (VIS) Inactivated Influenza Vaccine Information Statement, as well as the above information, and have had the opportunity to ask questions [please initial ____]. I understand the benefits and risks of the inactivated influenza vaccine as described. I request the flu vaccine to be administered to me or to the person named for whom I am authorized to sign.

____ ________________________________

Signature: Patient or Authorized Representative Date

I request that this provider be paid authorized Medicare/Medicaid/Private Insurance benefits on my behalf for any services furnished to me. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services. **I understand that I am responsible for the charges if my Medicare/Medicaid/Private Insurance coverage is not appropriate.**

Patient or Authorized Rep Signature ______________________________ __Payment to Patient √ **Payment to Provider**

Vaccine product & Lot # ____ Expiration Date _________________

Sight of injection: ☐ Right Deltoid ☐ Left Deltoid Clinic: Hemmingsen Drug Store

Administrator Signature and Date ____