Rambo Memorial Health Center

Location : _____

Receipt # _____

Initials_____

Please PRINT: **2024-2025 Influenza Vaccine Consent** **(Please fill out complete-**

Today's Date: _____

Name:_____

FIRST MIDDLE INITIAL LAST

Address: _____

City:_____ State: _____ Zip:_____ **County**:_____

Sex: M F Birthdate: _____ AGE: _____ Phone#: _____

MM — DD — YYYY

CONSENT TO TREAT: By signing this form, I agree to the following: I understand there is always a possibility of an adverse reaction to any vaccine or drug. I understand the benefits and risks of influenza vaccine. I have been offered a copy of the CDC Vaccine Information Sheet. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request..

HIPAA: I have been offered the Agency's Notice of Privacy Practices and understand that my protected health information may be used by the Agency as described in the notice.

SIGN HERE

Please answer the following questions:

1. Are you allergic to eggs, mercury, latex, thimerosal, or gelatin?	Yes	No
2. Have you ever had a serious allergic reaction to a previous dose of flu vaccine?	Yes	No
3. Do you have a history of Guillain-Barre?	Yes	No
4. Do you NOW have a fever or are you severely ill?	Yes	No
5. Are you pregnant or planning to get pregnant soon?	Yes	No
6. Have you had COVID-19 or had a potential exposure to COVID-19 in the last two weeks?	Yes	No

SIGNATURE : _____ **(Patient or Parent/Guardian)**

For Clinic Use Only

Date: _____ GIVEN BY: Signature: _____ **VIS** 8/6/2021 Given [ ]

Site Given: RA LA RT LT **Flulaval 0.5ml.** _____ Exp: 06-30-2025

Fluzone 0.5 ml_____Exp 6-30-2025

Fluad HD 0.5ml_____ Exp _____ **Fluzone HD 0.7 ml.**_____EXP____