



## 2018 Influenza Vaccine Consent Form

2882 N. Druid Hills Rd. NE Ste B, Atlanta, GA 30329  
678-805-7981  
[www.urgentcareatdruidhills.com](http://www.urgentcareatdruidhills.com)  
Fax # 678-550-6509

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

Telephone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Apt# \_\_\_\_\_

### Before consenting to receiving the influenza vaccination:

- Please read the "Influenza Information Sheet" provided to you prior to your vaccination
- Please Read the questions below; if you answer YES to any of the questions, please discuss with your immunization provider
- The information you provide is private and confidential and will not be used for any other purpose

Questions for discussion: (Please check appropriate boxes)	Yes	No
1. Do you have an acute fever or illness at present?		
2. Have you been vaccinated against the flu in previous years?		
3. Have you experienced any significant problems after vaccination?		
4. Are you allergic to eggs or chicken feathers or thimerosal (Mercury-based preservative)?		
5. Are you allergic to neomycin, polymyxin or gentamincin or Latex?		
6. Are you taking any cortisone, steroid, immunosuppressive medicine or theophylline, warfarin, Dilantin?		
7. Have you ever had Guillian-Barre Syndrome?		
<b>If Yes, please specify</b>		
8. Have you ever fainted when given an injection?		
9. <b>FOR WOMEN:</b> Are you pregnant or breast-feeding?		

<b>MEDICARE PART B: <u>Identification</u></b> Number: _____		
(please circle)	<b>Do you have a Secondary Insurance carrier?</b>	
	Yes	No
If YES: <u>Insurance Carrier</u>		
Name: _____		Group
Number: _____		Member ID: _____

Consent:

- I have read and understood the influenza information sheet about the risk of the influenza vaccination including the risks of not being vaccinated
- I have been given the opportunity to discuss the risks and benefits with my immunization provider
- I consent to receiving the influenza vaccine injection and inclusion on clinic database
- Furthermore, I hereby release and forever discharge myself, my heirs, executors, administrators and assignees, Urgent Care at Peachtree and their employees, owners and representatives as well as any company sponsoring this event and demands, actions and causes of action, which may result from participation in this program.
- I understand that consent can be withdrawn at any time prior to vaccination

<b>For Office Use Only</b>	
<b>For Office Use Only</b>	
Date Given:	Manufacturer:
Lot Number:	Exp. Date:
Site-Deltoid (Check one: L            R)	Influenza Vaccine given by:
Provider Signature:	

**Patient / Parent / Guardian**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_