

CONSENT FOR FLU VACCINE - INACTIVATED

Tax ID # 75-2743883
 UPIN # C21953
 Diagnosis: V04.81
 Flu Vaccine: 90658
 Administration: G0008

Name: (print) _____ Date of Birth _____ Age: _____

Have you ever had a flu vaccine before? ___Yes___No

DO NOT take the Inactivated Influenza Vaccine if any of the following apply:

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | You have serious allergy to eggs, chickens, chicken feather, chicken dander or thimerosal (a mercury-containing organic compound) |
| <input type="checkbox"/> | <input type="checkbox"/> | You have fever or a moderate to severe illness today (does not include minor illnesses) |
| <input type="checkbox"/> | <input type="checkbox"/> | You have a history of Guillain-Barre Syndrome (a paralyzing illness) or active neurological disease |
| <input type="checkbox"/> | <input type="checkbox"/> | You have a latex sensitivity |
| <input type="checkbox"/> | <input type="checkbox"/> | You are under 6 months of age |
| <input type="checkbox"/> | <input type="checkbox"/> | You have had a severe reaction after a previous dose of influenza vaccination, any other vaccine or vaccine component |
| <input type="checkbox"/> | <input type="checkbox"/> | You are pregnant (if you are, consult your physician) |
| <input type="checkbox"/> | <input type="checkbox"/> | You have a bleeding disorder hemophilia or thrombocytopenia |

I have requested that Covenant Health System administer the flu vaccine to me.

I have been given a copy and have read, or had explained to me, the information in the "Vaccine Information Statement for Inactivated Influenza Vaccine". I understand the benefits and the risks of the vaccine and ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I understand that this "seasonal" influenza vaccine does not protect me from the pandemic H1N1 (swine) influenza.

I have been offered a copy of the "Privacy Act Statement" and understand that my health information will not be disclosed unless otherwise noted in the information regarding my privacy rights. I was given the opportunity to ask questions about both forms.

I accept that services might be rendered in a non-private setting. I hereby consent to the administration of the flu vaccine. Furthermore, I hereby release Covenant Health System, its employees, representatives and agents, as well as the company sponsoring this event and their agents, representatives and employees from any liability for any property damage or personal injury arising directly or indirectly from any act or omission that may occur during the administration, or may occur because of adverse affects of the vaccine. I will communicate the information provided to me today about by vaccination to my primary care physician, if I have one.

 Signature of Recipient

 Date

Dosage	Route	Site	Needle Size	Time	Manufacturer	Lot #
0.5cc	IM	L R Deltoid	22ga.	am/pm	Flulaval Biomedical Corp. of Quebec	AFLLA275AA Expires 6-2010

Office use only:

Anything unusual happen? No Yes Explain: _____

Payment Amount: _____ Check Cash Company Pay

 Signature of Administering Nurse

 Date

11-5-09