PATIENTS FIRST HEALTH CARE

CONSENT AND RELEASE FOR INFLUENZA VACCINE

I have read the information on the explanatory form about influenza and the influenza vaccine and I understand this information, including the possible side effects of which some are known and some are unknown, unforeseen, and unforeseeable, and have had the opportunity to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and request and authorize the staff and agents of Patients First Health Care to administer the vaccine to me.

I acknowledge that I should not receive the vaccine if any of the following conditions apply to me:

- ✓ Allergy or hypersensitivity to eggs (or other components of the vaccine including thiomerisol); Y___ N___
- ✓ Allergy to aminoglycosides (such as gentamycin or garamycin); Y___ N___
- ✓ A past history of Guillain-Barre' syndrome; Y___ N___
- ✓ If I currently have a fever or acute respiratory illness Y___ N___
- ✓ If I am pregnant and do not have written authorization from my physician Y___ N___

I am relying on my own judgment in choosing to be vaccinated and I am not relying on any representatives or statements made by the Facility, its employees, and agents, or anyone representing Patients First Health Care. Having voluntarily consented to this vaccine and vaccination, I hereby fully and forever release and discharge Patients First Health Care, its employees and agents from any all harm, injure, losses, costs, claims, demands, damages, action, causes of action, or suits of any kind or nature whatsoever, whether known or unknown, now accrued or hereafter arising from or in any way related to or connected with me receiving this vaccination.

PLEASE PRINT:

_____

Last Name First Middle Initial Date of Birth

_____

Street Address City/State Zip Code Phone #

_____

Signature **Date**

(Signature of parent or guardian required if under 18 years of age)

Allergies: _____ Dose administered: _____0.5 cc_____

Site of Administration: L Deltoid_____ R Deltoid _____ Reaction at 5-10 minutes: Y _____ N _____

Manufacturer/Lot Number: _____

Nurse Signature: _____ Date: _____

Privacy Notice Given: □ Yes □ No