

Corporate Wellness Consultants
Flu Vaccination Consent and Release Form

PLEASE NOTE: It is the responsibility of each potential flu recipient to speak to their own primary care physician BEFORE arriving at the clinic regarding ANY questions they might have about receiving a flu shot.

Name _____
Company Name and
Address _____
City _____ State _____ Zip _____

Are you at least 18 years of age? Yes _____ No _____ Sex: Male _____ Female _____

Please read and sign before receiving the flu vaccine:

The U.S. Public Health Service recommends a vaccination for any individual who wishes to reduce his or her chances of becoming infected with influenza.

The vaccine is highly recommended for the following high risk individuals:

- * Adults with heart disease, lung disease, kidney disease, diabetes, or anemia.
- * Adults with impaired breathing capacity from chronic obstructive lung disease, or heavy smoking, neuromuscular or orthopedic conditions.
- * Persons over the age of 65

WARNING:

Some people should check with their primary care physician before taking the influenza vaccine:

- * Persons with allergy to egg, or egg products, that causes a dangerous reaction if they eat eggs, and those who have had a serious reaction to previous flu vaccines.
- * Anyone who has had an allergic reaction to the flu or other vaccine.
- * Anyone allergic to thimerosal (in eye contact lens solution) or mercury.
- * Anyone who has ever been paralyzed with Guillain-Barre Syndrome should seek advice from their physician about special risks that might exist in their case.
- * Women who are or might be pregnant should seek advice from their doctor.
- * Persons who are ill and have fever or a current respiratory infection should consult with their doctor on whether or not to delay the vaccination.
- * Persons with bleeding/coagulation disorders and/or who are on blood thinners.
- * Anyone who is immuno-suppressed (taking steroids, undergoing chemotherapy, etc.).

If you have any questions about influenza or influenza vaccine, please ask now or call your doctor before requesting the vaccine.

CONSENT:

I agree to contact my primary care doctor if I have any concerns or an adverse reaction to the flu vaccination. If I'm receiving a flu shot for the first time, I agree to remain at the flu clinic after receiving my shot for 20 minutes in order to be monitored. Should I experience any of the following shortly after receiving the flu shot: shortness of breath, difficulty swallowing/swelling in the throat or chest pain/tightness, or any swelling or redness at the injection site, I will immediately report back to the flu shot station for follow-up. I have read the information on this form about influenza and the influenza vaccine. I have had a chance to ask questions about the contents of this form, which were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine and hereby consent to have the flu vaccine administered to me. I further agree to hold harmless Corporate Wellness Consultants,

LLC and my employer as well as either party's subsidiaries, officers, employees, agents, representatives, contractors, successors and assignees any claim, or action arising out of or, in any way incidental to this vaccination. I hereby state that I am 18 years or older, under no duress, and have read and understood this informed consent for influenza virus vaccination. I will communicate the information provided to me today about my vaccination to my primary care provider, if I have one.

Signature: _____ Date: _____

RN Use	Had flu shot before? Y___N___	(If no, tell them to sit for 20 minutes.)
Prior allergic reaction to flu/other vaccine? Y___N___	Pregnant? Y___N___ if yes: 1st __ 2nd __ 3rd __ trimester	
Guillain-Barre? Y___N___	Bleeding disorder? Y___N___	Vaccine _____ Lot # _____ Exp. Date _____
	Currently sick/fever? Y___N___	Left arm _____ Right arm _____
Thimerosal/mercury allergy? Y___N___		RN Signature _____ _____