



INJECTABLE FLU VACCINE CONSENT AND RELEASE

I have had an opportunity to consult Mercy Clinic Professionals or their agent regarding any questions I may have about the immunization program. I understand the risk associated with the influenza vaccine as described and the conditions under which I or my child should not get the influenza vaccine. I hereby voluntarily request and authorize the Mercy Clinic or their agents to administer the influenza vaccine to me or my child.

In consideration of receipt of the influenza vaccination, I expressly release and discharge Mercy Clinic and/or their agents from all claims and demands, of whatever nature, resulting from the administration of the vaccine to me or my child.

Patient Name: _____ DOB: _____ Age: _____

Does the patient have a fever? (If mild viral symptoms and the temp is below 100, vaccine can be given). People on antibiotics over 24 hours can be given the vaccine.	<input type="checkbox"/> No <input type="checkbox"/> Yes
Has the patient had an allergic reaction to the vaccine? (Rashes, hives and systemic anaphylactic symptoms, etc.)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is the patient allergic to chicken eggs? (anaphylactic level)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is the patient within their first trimester of pregnancy (OB has confirmed safe to receive vaccine.)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is the patient allergic to Thimerosal? (Commonly used in contact lens solution. History of significant reaction.)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Does the patient have a history of Guillain-Barre Syndrome?	<input type="checkbox"/> No <input type="checkbox"/> Yes
I have received or previously received the Mercy Clinic Notice of Privacy Practices. _____ (Initial Here)	

I have read the above information about the injectable influenza vaccine and have truthfully answered all of the questions on this form. I have also received a copy of the Vaccine Information Statement for the injectable influenza vaccine. I have had a chance to ask questions and fully understand the benefits and risks of the injectable influenza vaccine. My signature below indicates my permission for the injectable influenza vaccine to be given to the patient listed above.

 Printed Name of Person filling out form

_____/_____/_____
 Date

 Signature of Patient or Guardian

 Relationship to the patient

Questions reviewed by: _____

Administered by: _____
 Vaccine/Lot Number/ Expiration Date documented in EPIC