Neighborhood Medical Center
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Dallas, TX 75254
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2019-2020 Influenza Vaccine ~ Consent Form

Patient Name__________________________________ Date of Birth ______________

Street Address__________________________ City__________ State________ Zip Code________

HM.Phone # ______________________ Cell # ______________________

- **Before consenting to receiving the influenza vaccination please read the questions below and 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 tick appropriate boxes)*

#	Question	Yes	No
1	Do you have an acute feverish illness at present?	Yes ☐	No ☐
2	Have you been vaccinated against the flu in previous years?	Yes ☐	No ☐
3	Are you currently receiving chemotherapy, radiation therapy or immunosuppressive therapy?	Yes ☐	No ☐
4	Have you experienced any significant problems after vaccination?	Yes ☐	No ☐
5	Are you allergic to eggs or chicken feathers?	Yes ☐	No ☐
6	Are you allergic to neomycin, polymyxin or gentamicin?	Yes ☐	No ☐
7	Are you taking any cortisone, steroid, immunosuppressive medication or theophylline, warfarin or dilantin?	Yes ☐	No ☐
8	Do you have a past history of Guillain-Barre syndrome?	Yes ☐	No ☐
9	Do you have any hypersensitivity to any component of the vaccine, including thimerosal?	Yes ☐	No ☐

If *Yes*, please specify____

#	Question	Yes	No
10	Have you ever fainted when given an injection?	Yes ☐	No ☐
11	FOR WOMEN: Are you pregnant or breastfeeding?	Yes ☐	No ☐

Consent

I understand the adverse reactions associated with the influenza vaccine and I am aware that a copy of the vaccine manufacturer's drug information sheet is available at the CDC website. Furthermore, I have also had an opportunity to ask questions about this immunization. I believe that the benefits outweigh the risks and I assume full responsibility for any reactions that may result. My medical record may be shared with my physician/insurance. I waive and release any and all claims I, or anyone claiming by or through me, now have or may hereafter acquire against Neighborhood Medical Center and the clinic manager, director, employees and agents for any and all damages or injuries arising out of or related to the receipt of the flu shot, including, without limitation, if I, the person named below for whom I am authorized to make this request, contract influenza, other respiratory diseases, or suffer any other damages or adverse reactions, including death, following administration of this flu shot. I am requesting that the immunization be given to me or the person named for whom I am the legal guardian.

Signature____ **Date** ____________

For Office Use Only

QUADRIVALENT (4YRS & OLDER)
LOT#: P100115062
EXP: JUNE 17, 2020

SITE: ________ IM Deltoid MA Initials: ____________ Date: ____________

Provider: Dr Martin McElya