2014-2015 Inactivated Influenza Vaccine Consent Form

Name of Individual to be Immunized _____

Address _____ Phone # _____

Date of Birth_____ Age_____ M ☐ F ☐

ID# _____

Please answer the following questions:

Are you sick or do you have a high fever today?	Yes ☐ No ☐ Unknown ☐
Are you allergic to chicken, eggs, or egg products?	Yes ☐ No ☐ Unknown ☐
Have you ever had an allergic reaction to a flu shot?	Yes ☐ No ☐ Unknown ☐
Are you pregnant, or think you may be?	Yes ☐ No ☐ Unknown ☐
Do you have a blood clotting disorder or are you taking blood thinning medication?	Yes ☐ No ☐ Unknown ☐

Acknowledgement:

1. I am at least 18 years of age. I have read or have had explained to me the inactivated influenza vaccine: "What you need to know", vaccine information sheet. I have been given the opportunity to ask a USC health care professional concerning the influenza vaccine, including the risks and benefits of receiving the influenza vaccine. All of my questions concerning the vaccine have been answered to my satisfaction. I understand the benefits and risks of the influenza vaccine and request that it be given to me.
2. I affirm that I am not allergic to eggs, chicken, thimerosal, albumin products or a previous dose of the influenza vaccine. I do not have a history of Guillain-Barre' Syndrome (GBS).
3. I understand my medical care provider may submit this immunization information to the state immunization registry.

Release of Liability:

I have read and I understand the acknowledgements set forth above, and I hereby release the University of Southern California and USC Care Medical Group and their affiliated entities, and all of their agents, employees, trustees, and representatives, from any and all liability which may arise from the vaccination and/or from the information provided to me concerning such vaccination.

Consent to the Vaccination:

I have read and I understand the information set forth in this form. Based on that understanding, I hereby CONSENT to an inactivated influenza vaccination provided to me by USC Care Medical Group.

_____ _____

Signature of Recipient of the Vaccination Date

If signed by someone other than recipient, please indicate name and relationship. _____

_____ _____ _____

Signature of Witness Date Printed Name of Witness

For Office Use Only

Flu vaccine Lot #: _____ Exp: _____ Date: _____

Site of Injection: R L Deltoid _____