INFLUENZA VACCINE (FLU SHOT) CONSENT FORM

1.	**Have you ever had an allergic reaction to flu vaccine?**	**YES OR NO**
2.	**Are you allergic to eggs or egg products?**	**YES OR NO**
3.	**Do you have a history of Guillain-barre Syndrome? (illness associated with the swine flu in 1976 characterized by fever, nerve damage, and muscle weakness)**	**YES OR NO**
4.	**Are you allergic to theimerosal (a mercury-based preservative)?**	**YES OR NO**
5.	**Are you allergic to latex?**	**YES OR NO**
6.	**Do you feel ill today or do you have a fever?**	**YES OR NO**
7.	**If you are female, are you pregnant? # of weeks: _____**	**YES OR NO**

I hereby certify that the foregoing history is true and complete to the best of my knowledge and I have received and read the "Vaccine Information Statement" from the CDC, have had an opportunity to ask questions that were answered to my satisfaction, and do wish to receive the flu vaccination fully understanding the risks and the benefits. I hereby consent to the administration of the flu vaccine (flu shot). Furthermore, I hereby release and forever discharge for myself, my heirs, executors, administrators and assignees, KMM—Kaiser Medical Management and their employees, owners and representatives, contract workers and any/all health providers involved with providing this service, as well as the company sponsoring this event and their agents, representatives, employees, successors, assignees, governing bodies, and advisory committees from any and all claims, demands, actions and causes of action, which may result from participation in this program.

Your personal information and results shall be held strictly confidential. I understand KMM-Kaiser Medical Management is not a Medicare participating provider. Insurance/Medicare will not be billed.

PARTICIPANT INFORMATION & CONSENT

PLEASE PRINT:

FIRST NAME: _____ LAST NAME: _____

ADDRESS: _____ CITY: _____ STATE: ___ ZIP: ____

PHONE: _____ EMAIL: _____

BIRTHDATE: _____ AGE: _____

SIGNATURE: _____ DATE: _____

FOR OFFICE USE ONLY

MANUFACTURER & LOT#: _____ NOVARTIS—FLUVIRIN LOT: _____

EXPIRATION DATE: _____ SITE OF INJECTION: R / L DELTOID

SIGNATURE & TITLE OF VACCINE ADMINISTRATOR: _____

Cash: $ _____ Check: $ _____ Credit Card: $ _____ Co. Sponsored: _____ Other: _____