



Influenza Screening & Consent Form

Please answer the following questions:

✓ **check your answer**

1. Have you ever had a flu shot? YES NO
2. Are you over the age of 18? YES NO
3. Have you ever had an adverse (allergic) reaction to a flu shot?
If so, please describe your symptoms to the nurse. YES NO
4. Are presently ill? (i.e. fever, cough with colored mucus)
If so, please describe your symptoms to the nurse. YES NO
5. Are you allergic to eggs or egg products? YES NO
6. Have you ever had paralysis associated with Guillian-Barre Syndrome? YES NO
7. FOR WOMEN ONLY-
- Are you Pregnant or Nursing? YES NO

Please read the following statement:

I have read or have had explained to me the annual influenza vaccine information statement. I have had an opportunity to ask questions, which were answered to my satisfaction. I believe, understand and accept the benefits and risks of the influenza vaccine and request that it be given to me or the person for whom I am authorized to make this request. I hereby release HealthFax, Inc., and any associated company from any and all liability from or in anyway connected to receiving this immunization.

Print Name Here

Sign Name Here

Date

This section: HealthFax Staff Only

Date of Event:

Location of Clinic:

Staff Initials:

Vaccine Lot#:

Expiration Date:

Dosage: .5ml

Injection Site: R. Deltoid
(circle one)

L. Deltoid

Manufacturer:
(check one)

Sanofi Pasteur:

GSK:

Novartis (Chiron):

CSL: