# INFLUENZA VACCINATION ASSESSMENT AND CONSENT FORM

Yes No

☐ ☐ Are you allergic to eggs, egg products, latex, or thimerosal (found in some eye cosmetics, ear, nose, and eye medications)?

☐ ☐ Are you sick with a fever greater than 100°F?

☐ ☐ Do you have a history of Guillain-Barre' Syndrome or any other neurological disorder?

☐ ☐ Do you have a bleeding disorder (thrombocytopenia, low platelet count)?

☐ ☐ Do you smoke, have asthma, or another chronic condition (such as diabetes)?

☐ ☐ Have you ever had a severe allergic reaction (food, medicine, flu shots, other) such as hives, breathing difficulty, shock or anything requiring emergency medical treatment or within 48 hours of a previous vaccine? If yes, specify: _____.

_____

## QUESTIONS

If you have any questions about the Influenza Disease or the Influenza Vaccination, please ask the clinician now or call Careline Physician Services before requesting the vaccine. If you have any questions, concerns following the vaccination, or experience adverse side effects please call Careline Physician Services at (800) 490-1742.

## CONSENT AND RELEASE FOR INFLUENZA VACCINE

- I have read the 2022 VIS regarding the Influenza Vaccine. I have had an opportunity to ask questions, and my questions have been answered to my satisfaction. I understand the benefits and risks of the Influenza Vaccination as described. I request that the vaccine be given to me. I understand the vaccination is being provided to me by Careline Physician Services. **I expressly release Careline Physician Services and its affiliates from any liability resulting from the Influenza Vaccine itself.**
- I agree to remain under observation for at least 15 minutes. Should I leave before that period lapse, I expressly release Careline Physician Services and its affiliates from any liability results from any adverse reaction to the vaccine which may occur during that period and thereafter. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense. I understand side effects may include but are not limited to: soreness at the injection site, fever, fatigue, and headache. There is some risk for Guillain-Barre Syndrome. Severe reaction may include anaphylaxis and death.
- In the event a Careline Physician Services employee or its affiliates is exposed to my blood or other body fluids, I agree to have my blood tested for HIV and Hepatitis and have the results released to Careline Physician Services, but not to anyone else unless required/authorized by law.
- I acknowledge that I have received written information on Careline Physician Services' "Notice of Privacy Practices" prior to the provision of services, and I have had the opportunity to have my questions answered.
- I wish to have Careline Physician Services bill my insurance for the cost of my shot. Careline Physician Services Agrees to accept provider payment.
- I acknowledge that I am responsible to reimburse Careline Physician Services for charges not covered by my insurance.

## PATIENT INFORMATION

| | | | | |
|---|---|---|---|---|
| LEGAL NAME: | | CIRCLE ONE: M F | DOB: | AGE: |
| MANUFACTURER: | EXP: | LOT: | DOSE: 0.5CC IM R L DELTOID | |
| SIGNATURE: | | | DATE: | |
| ADMINISTERED BY: | | | DATE: | |