

INFLUENZA VACCINATION RELEASE AND CONSENT

Date: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____ City: _____ Zip: _____

Phone Number: _____

Cost: \$25.00 unless you meet any of the following criteria.

_____ I am Medicare Part B eligible, my Medicare number is _____.

_____ I am under age 18 and on Medicaid or do not have health insurance coverage.

Please answer the following questions by circling the appropriate responses:

1. Are you allergic to chicken, eggs, chicken feathers, or mercury? Yes No
2. Have you ever had a reaction to a flu shot, such as French polio? Yes No

I have read the information and have had the chance to ask questions. I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me, or the person named above. I accept responsibility for seeking medical attention for any problems with this vaccination. I authorize billing of this vaccination to Medicare or Medicaid, if applicable.

Patient/Parent Signature: _____

*****FOR OFFICE USE ONLY*****

LOT NO.:

MANUFACTURER: Aventis

EXPIRATION DATE: 6/30/2008

Site: Rt thigh / Lt thigh / RD / LD

Dose: 0.25cc IM / 0.5 cc IM

Nurses Signature: _____