Flu Shot Authorization Form

MIDLAND HEALTH TESTING SERVICES, INC VACCINATION CONSENT FORM (PLEASE PRINT)

Name Last: _____First: _____

Company/Sponsor:_____

Location and Address: _____

City :_____ State:_____ Zip: _____

Date of Birth: __/___/___ Sex: M F Phone Number _____

Please talk to your doctor before being vaccinated especially if you have history of allergies and answer the following questions yes or no.

1. Have you ever had a flu shot before? Y_____ N_____
2. Are you allergic to thirmerosal, eggs or egg products? Y_____ N_____
3. Have you EVER had an allergic reaction to flu or other vaccine? Y_____ N_____
4. Are you pregnant? * Y_____ N_____
   *The flu vaccine is considered safe for pregnant woman however; it is against CALIFORNIA LAW to administer a flu shot from a multi dose vial to a pregnant woman (and children) due to thimerosal.
5. Are you currently sick (this does not include a minor illness)? Y_____ N_____
6. Do you have a history of Guillian-Barre Syndrome (a severe paralytic illness)? Y_____ N_____
7. Are you allergic to latex? Y_____ N_____ PLEASE NOTIFY THE NURSE!

I have received and read the CDC information sheet for the flu vaccination and have had the opportunity to ask any questions. I have also had the opportunity to read and consider the Midland Health privacy and practice statements prior to this consent. I accept that services may be administered in a non-private setting. I agree to remain at the clinic for a period of at least 10 minutes if this is my first vaccination of this type. I hereby consent to the administration of the flu vaccine. Furthermore, I hereby release and forever discharge for myself, my heirs, executors, administrators, and assignees, Midland Health Testing Services, Inc , their owners and representatives 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. I will communicate the information provided to me today about my vaccination to my primary care provider if I have one so a record can be kept.

Signature: _____ Date:_____

For Clinic Use Only

Date: Nurse: _____ Rt. Arm____ Left. Arm_____

Lot Number: Exp Date: Vaccine Name: