FluShot4you.com™
P.O. Box 44413 • Boise, ID 83711 • (203)378.4584

INFLUENZA VACCINE (FLU SHOT) CONSENT FORM 2009-2010

A/Brisbane/59/2007 (H1N1)-like virus — A/Brisbane/10/2007 (H3N2)-like virus — B/Brisbane/60/2008-like virus

1. **Have you ever had a severe 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 thimerosal (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? # Weeks______** — **Yes or No**

Heard about the clinic from: Newspaper / Physician / Street Sign / Employer / Store Adv.
(Circle all that apply) Friend or Relative / E-mail / Prior Patient / Other __________

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 2009-2010" 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, NW Health and OsteoScreening / FluShot4you and their employees, 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. *Your personal information and results shall be held strictly confidential. I understand Northwest Health and OsteoScreening/FluShot4you is not a Medicare participating provider. Insurance/Medicare will not be billed; however, forms/receipts are available for reimbursement.*

PARTICIPANT INFORMATION AND CONSENT

LAST NAME:	**FIRST NAME:**	**MI:**	
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
PHONE:	**E-MAIL:**		
BIRTHDATE:	**AGE:**		
SIGNATURE: (Parent/Guardian consent required if 17 yrs and under)		**DATE:**	

FOR CLINIC USE ONLY

MANUFACTURER AND LOT#:	Novartis – FLUVIRIN Lot **#**
EXPIRATION DATE: June 30, 2010	
SITE OF INJECTION: R / L DELTOID	
SIGNATURE AND TITLE OF VACCINE ADMINISTRATOR:	
PAYMENT Cash $______________ Check $______________ Credit Card $______________ FLUGRAM__________Co. Sponsored _______	