Affinity Immediate Care

VACCINATION CONSENT FORM

Name (print): _____ MRN #_____

Address: _____ _____

Date of Birth _____ Gender: ____Male ____Female

Please answer the following questions:	Yes	No	Unknown
Are you sick, or do you have a fever greater than 100.5 today? (if yes, you should not receive vaccine)			
Have you been sick in the last 2 weeks?			
Are you allergic to chicken, eggs, or egg products? (Flu only)			
Have you ever had an allergic reaction to an immunization?			
Are you pregnant, or think you may be?			
Do you have a blood clotting disorder or are you taking blood thinning medication?			

CONSENT AND RELEASE STATEMENT

I, THE UNDERSIGNED, WISH TO RECEIVE A VACCINATION. I AM TAKING THIS VACCINATION VOLUNTARILY AND CONSENT TO THE VACCINATION BEING GIVEN TO ME. I HAVE READ THE PROVIDED INFORMATION OR HAVE HAD SUCH EXPLAINED TO ME. I UNDERSTAND THE RISKS AND BENEFITS OF THESE VACINE/VACCINES. I HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS WHICH HAVE BEEN ANSWERED TO MY SATISFACTION. I HEREBY REQUEST THAT THE VACCINE BE GIVEN TO ME OR TO THE PERSON NAMED ABOVE FOR WHOM I AM AUTHORIZED TO MAKE THIS REQUEST.

_____ _____

SIGNATURE DATE

FOR OFFICE USE ONLY					
DATE GIVEN	MANUFACTURER & LOT NUMBER	EXPIRATION DATE	SITE	ROUTE	ADMINISTERED BY: