



Tulsa, OK
 Oklahoma City, OK
 Norman, OK
 Fayetteville, AR

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Flu Vaccine Consent Form

Patient Information and Consent

*****PLEASE PRINT CLEARLY*****

Last Name: *		First Name: *		Middle Initial: *	
Contact Phone:		Employer:			
Birth Date: *		Gender: *	<input type="checkbox"/> Male <input type="checkbox"/> Female		

Flu Vaccine Questionnaire

Have you ever had an allergic reaction to flu vaccine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you allergic to eggs, or egg products?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a history of Guillain-Barre Syndrome?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you allergic to Thimerosal (a preservative)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you allergic to latex?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel ill today or do you have a fever?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If you are female, are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

I hereby certify that the foregoing history is true and complete to the best of my knowledge and have had an opportunity to ask questions that were answered to my satisfaction, and do wish to receive this procedure fully understanding the risks and the benefits. Risk and possible side affects could include soreness, fever, aching for one or two days. As with most drugs or vaccines, there is possibility of allergic reaction or more serious reactions, even death, could occur. I hereby consent to the administration of the vaccine.

Furthermore, I hereby release and forever discharge for myself, my heirs, executors, administrators and assignees, PicMed Wellness 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 PicMed Wellness will not bill insurance; however, forms/receipts are available for reimbursement.

Signature:		Date:	
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FOR CLINIC USE ONLY

Immunization Given	Mfg.	Lot#	Exp. Date	Injection Site	Administered By Initials	Dose #1	Dose #2	Payee	
2018/19 Influenza Quadrivalent-5 yrs +	Seqirus Afluria			R / L Deltoid IM R / L Thigh Anterolateral				Employer	<input type="checkbox"/>
2018/19 Influenza Quadrivalent-4 yrs+	Seqirus Flucelvax			R / L Deltoid IM R / L Thigh Anterolateral				Cash	\$ _____
2018/19 Influenza Quadrivalent-6mo+	Sanofi Fluzone			R / L Deltoid IM R / L Thigh Anterolateral				Check	\$ _____
2018/19 FluMist Quadrivalent-2 to 49	MedImmune	N/A	N/A	Intranasal Spray					# _____

