Celina Medical Clinic

Consent & Release – Injectable Vaccinations

Last Name	First	Date of Birth		
_____	_____	___/___/_____	_____Male	_____ Female

Address	City	St	Zip	Contact Phone #
_____	_____	___	_____	_____

I acknowledge that I understand the benefits and risks of the requested vaccination as described in the Vaccine Information Sheet, a copy of which has been provided. I confirm that Celina Medical Clinic has answered to my satisfaction all of my questions about the vaccine and vaccination procedure. I request consent that the vaccination be given, as I direct by Celina Medical Clinic, either to me or to the person named above, a minor for whom I represent, that I am authorized to sign this Consent and Release. I understand that I am giving Celina Medical Clinic my permission to release any medical or other information necessary to Medicare, as applicable, to enable Celina Medical Clinic to process my insurance claims with respect to the vaccination.

I, for myself (and the recipient of the vaccination, if the recipient is a minor), my heirs, executors and assigns hereby release Celina Medical Clinic and their respective employees and representatives from my and all claims arising out of or in connection with the quality of the above-described vaccine as provided by the manufacturer and any negligence of Celina Medical Clinic in connection with the related injection of the vaccination. I understand that the laws of my state may affect my remedies in connection with this vaccination.

X_____ _____

Signature of person to receive vaccine, or Parent/Guardian if recipient is a minor **Date**

Please answer the following questions by circling Yes or No. If the question is not clear, please ask for assistance.

1. Are you currently sick or have a fever? (greater than 101.0 F, breathing problems or active infection)	**Yes**	**No**
2. Have you ever had a serious reaction to a flu vaccine? (tightening in your throat or inability to breathe, allergic reaction immediately after a previous vaccine)	**Yes**	**No**
3. Do you have a history of Guillain-Barre Syndrome (GBS)?	**Yes**	**No**
4. Do you have an allergy to eggs, egg products, thimerosal or latex?	**Yes**	**No**
5. Are you pregnant or planning to become pregnant in the next month or currently breast feeding?	**Yes**	**No**

For Office Use Only:

Vaccine: Fluvirin **Lot**: 145003 **Exp Date:** 03/31/2015 **Manufacturer:** Novartis **Dose:** 0.5ml

Site of Administration: _____ **Given by**: _____

Payment: $25.00 Cash Check # _____ Visa MC Amex Disc