Herald Christian Health Center

923 S San Gabriel Blvd, San Gabriel CA 91776
Phone: 626-286-8700 Fax: 626-286-8650

Flu Vaccine Consent Form

Last Name:__________________________ **First Name:** _____________________________

Address: ____

City:____________________________ **State:** ____________ **Zip:** __________________

Phone: ______________________ **Date of Birth:** ___________ ☐ **Male** ☐ **Female**

Please answer the following questions:	**Yes**	**No**	**Unknown**
1. Are you sick or do you have a high fever today? (If Yes, you should not receive vaccine)	☐	☐	☐
2. Are you allergic to thimerosal, eggs or egg products?	☐	☐	☐
3. Have you ever had an allergic reaction to a flu shot?	☐	☐	☐
4. Are you pregnant, or think you may be?	☐	☐	☐
5. Do you have Guillain-Barr Syndrome?	☐	☐	☐
6. Have you been tested positive for COVID-19 **OR** have you had direct contact with someone who tested positive for COVID-19 in the last 2 weeks?	☐	☐	☐
7. Have you travel to another country in the last 2 weeks?	☐	☐	☐

CONSENT AND RELEASE STATEMENT

I. THE UNDERSIGNED, WISH TO RECEIVE A VACCINATION AGAINST INFLUENZA. I AM TAKING THIS VACCINE 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 THIS VACCINE. 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:** _________________________

Date Given	Manufacturer & Lot #	Site (circle one)	Dosage	Administered By:
	Sepirus Afuria -P100240252	RD LD	0.50 ml	