Southern PHARMACY SERVICES
A Guardian Pharmacy®

ON-SITE INFLUENZA VACCINE CONSENT FORM

1. Read the following questions and circle either **YES** or **NO**.

- Are you allergic to eggs? .... **YES** **NO**
- Do you have a history of Guillain-Barre' Syndrome? .... **YES** **NO**
- Are you receiving treatment that may affect the immune system? .... **YES** **NO**
- Are you sick with a fever or have a moderate to severe illness? .... **YES** **NO**
- Are you pregnant or think you may be? .... **YES** **NO**
- Are you allergic to thimerosal? .... **YES** **NO**
  (mercury-containing preservative used in the manufacturing of flu vaccine)
- Have you ever had a previous reaction to a flu vaccine? .... **YES** **NO**
- Do you have an active Neurologic disorder? .... **YES** **NO**
- Do you have a history of Latex sensitivity? .... **YES** **NO**
- Are you taking a blood thinner or steroids? .... **YES** **NO**
- Are you allergic to polymyxin or neomycin (antibiotic ointments)? .... **YES** **NO**

If yes, please describe the extent of the reaction ______________________________

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I hereby certify that the foregoing history is true and complete to the best of my knowledge. I understand the benefits and risks of influenza vaccine and had the chance to ask questions which were answered to my satisfaction. As with any vaccine, immunization with Influenza Virus Vaccine may not result in seroconversion of all individuals given the vaccine. I hereby waive any claim for damages that I (or anyone claiming on my behalf) may have against Southern Pharmacy Services, its employees and agents on account of any injury or misfortune I may suffer as a result of this vaccination. I request that the vaccine be given to me or to the person named below for whom I am authorized to sign.

Physician's order must be updated and on file with Southern Pharmacy Services for residents and employees.

INFORMATION ABOUT PERSON TO RECEIVE VACCINE (PLEASE PRINT)

LAST NAME: ____________________ FIRST NAME: ____________________ MI:______

ADDRESS: ____

CITY: ____________________ STATE: ____________________ ZIP CODE: _______

BIRTHDATE: ____________________ AGE: ____________________

SIGNATURE OF PERSON RECEIVING VACCINE: ______________________________

FOR NURSE'S USE ONLY

DATE VACCINATED: ____________________ SITE OF INJECTION: R / L DELTOID

MANUFACTURER & LOT # ____________________ EXPIRATION DATE: ____________________

SIGNATURE OF VACCINE ADMINISTRATOR: ______________________________

TITLE OF VACCINE ADMINISTRATOR: ______________________________