PRISMA HEALTH®

## Community Health Flu Shot Adult (16 and Over) Consent

Patient's name_____ Birth date____/____ /_____ Sex (optional)_____

Race (optional): Asian Black or African American Hispanic or Latino White Other

Address_____ City_____

State_____ ZIP code_____ Phone (____) _____

Physician's name/Phone number_____

Allergies_____

Please answer the following questions for the patient receiving the vaccine:

| | | | |
|---|---|---|---|
| 1. | Are you sick today? | Yes | No |
| | a. If yes, do you have a new fever, cough, diarrhea or vomiting? | Yes | No |
| 2. | Have you ever fainted or felt dizzy after receiving a vaccine? | Yes | No |
| 3. | Have you ever had a reaction to a flu vaccine? | Yes | No |
| | Describe reaction: _____ | | |
| 4. | Do you have any long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), anemia or other blood disorder? | Yes | No |
| 5. | Do you have a weakened immune system because of HIV/AIDS or other disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs? | Yes | No |
| 6. | Do you have allergies to latex, medications, food or vaccines (e.g., eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)? | Yes | No |
| 7. | Have you ever had a seizure disorder for which you are on seizure medications, a brain disorder, Guillain-Barre syndrome or other nervous system problems? | Yes | No |
| 8. | Women: Are you pregnant or considering becoming pregnant in the next month? | Yes | No |

I have read or have had explained the Vaccine Information Sheet provided about the vaccine I am to receive. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of vaccination and ask that the vaccine be given to the person named above for whom I am authorized to make this request. I have read and answered the questions on this form carefully and accurately. I understand that incorrect information could cause me serious risks. I understand immunization information about my vaccine will be reported to the SC immunization Registry for public health purposes. I hereby release and agree to hold Prisma Health, its board, physicians, employees, volunteers, medical staff and agents harmless, in and from any and all liability, claims, or damages arising or claimed as arising, out of or in relation to this consent.

X:_____ Date:_____

How did you hear about this clinic? Radio_____ Church_____ Other_____

Did you receive a flu shot last year? Yes_____ No_____

*Do not write below line – for internal use only.*

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Vaccine name: _____ Lot #_____ Exp_____ Amount_____

Site_____ Date given_____ Administered by_____

Documented in State Registry_____ Date documented_____