Texas Health Resources Zip CODE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Flu Vaccine Consent 7/27/21 ma

INFORMATION

I understand the following treatment is planned for me: Vaccination with either the inactivated influenza vaccine or the live, attenuated influenza vaccine.

Information as to the Risks and Benefits of the vaccine I am receiving has been reviewed on the provided Vaccine Information Statement (VIS).

I have been provided the Vaccine Information Statements of 8/06/21 for the Inactivated Influenza Vaccine and/or the Live, attenuated vaccine which have been developed by the Centers for Disease Control and Prevention.  I have been given the opportunity to read the applicable VIS for the vaccination I am to receive and if needed, I will have it read to me and ask any pertinent questions prior to receiving the vaccination.

I assume all risks and fully release and hold harmless Texas Health Resources, its subsidiaries, agents, employees and representatives, from any and all liability for any injury or illness that may occur from receiving the immunization.

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# PLEASE READ, COMPLETE AND SIGN:

# Please indicate your age range: \_\_\_\_\_17 or younger \_\_\_\_\_18 to 49 \_\_\_\_50 to 64 \_\_\_\_\_ 65 or older

# Are you pregnant? \_\_\_\_ Yes \_\_\_\_ No

# Are you currently breastfeeding? \_\_\_\_ Yes \_\_\_\_ No

* Do you provide regular, ongoing care or come in close contact with patients, or people in your household,

who are in any of the following categories: bone marrow transplant, pre- or post-organ transplant,

cancer patients receiving chemotherapy, or an immune system disease? \_\_\_\_ Yes \_\_\_\_ No

# Are you feeling moderately or severely ILL today? \_\_\_\_ Yes \_\_\_\_ No

# Have you taken Tamiflu, Relenza, Amantadine, Rimantidine (flu meds) in the past 48 hours? \_\_\_\_Yes \_\_\_\_ No

* Do you have any of the following chronic illnesses? Asthma, chronic lung disease, chronic heart

#  disease, diabetes, kidney dysfunction. \_\_\_\_ Yes \_\_\_\_ No

# Do you have a bleeding disorder (like hemophilia or low platelets) or are you taking a blood thinner? \_\_\_\_ Yes \_\_\_\_ No

* Do you have an immune deficiency? For example, do you have an immune system disease or take

immunosuppressive medicine? \_\_\_\_ Yes \_\_\_\_ No

# Has a doctor ever told you that you had "Guillain-Barre Syndrome" (GBS) a paralyzing nerve disease?

#  \_\_\_\_Yes \_\_\_\_ No

# Have you ever had a life threatening allergic reaction to a flu vaccine? \_\_\_\_ Yes \_\_\_\_ No

* Are you allergic to Thimerosal (a mercury derivative)? \_\_\_\_ Yes \_\_\_\_ No
* Have you ever had a life threatening allergic reaction to latex? \_\_\_\_ Yes \_\_\_\_ No
* Have you ever had a life threatening allergic reaction to formaldehyde? \_\_\_\_ Yes \_\_\_\_ No
* Have you had a life threatening allergic reaction to the antibiotics “gentamicin,” or “neomycin,”?” \_\_\_\_ Yes \_\_\_\_ No
* Have you ever had a life threatening allergic reaction to "arginine," or "gelatin"? \_\_\_\_ Yes \_\_\_\_ No
* Do you object to receiving pig products? \_\_\_\_ Yes \_\_\_\_ No
* Have you ever had a *severe* allergic reaction to any egg or chicken products? \_\_\_\_ Yes \_\_\_\_ No

 If yes, what kind of reaction do you get to eggs?

* + Able to eat lightly cooked egg (e.g. scrambled egg) with no reaction
	+ Hives
	+ Cardiovascular changes
	+ Breathing Difficulty (such as wheezing)
	+ Nausea/Vomiting
	+ Reaction requiring epinephrine shot or other emergency medical attention
	+ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I hereby certify that I have carefully read this Seasonal Flu survey, I understand it and the information given is complete, true and accurate to the best of my knowledge. I understand the falsification or misrepresentation of any of the information, or the failure or neglect to disclose any of the information may be grounds for termination from this program, regardless of when such falsification, misrepresentation, failure or neglect may be discovered.*

Print name: Signature: \_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_**  Fluarix Quad GSK **\_**06/30/22**\_ \_**0.5ml/IM/Deltoid **\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Date Lot Mfg Exp. Date Dose/Route/Site Nurse Signature**