OLYMPUS FAMILY MEDICINE

2020-2021

Flu Shot Consent Form – Participant Information – Consent for In-Office Treatment

1. **Have you ever had a flu shot in the past?** ____**Yes** ____**No**
2. **Have you ever had an allergic reaction to the flu vaccine?** ____**Yes** ____**No**
3. **Are you allergic to eggs or egg products?** ____**Yes** ____**No**
4. **Do you have a history of Guillain-Barre Syndrome?** ____**Yes** ____**No**
5. **Are you allergic to Thimerosal (a mercury-based preservative)?** ____**Yes** ____**No**
6. **Do you feel ill today, or have you been experiencing a fever or vomiting?** ____**Yes** ____**No**
7. **If you are a female, are you pregnant?** Number of Weeks Pregnant_____ ____**Yes** ____**No**

I hereby certify that the foregoing history is true & complete to the best of my knowledge and I have received & read the most current version of the CDC Vaccine Information Statement, and have had an opportunity to ask any questions. I understand the risks & benefits, and wish to receive this vaccination. Furthermore, I release & forever discharge myself, my heirs, executors, administrators & assignees: *Olympus Family Medicine*, their employees, owners & representatives, successors, assignees, governing bodies & advisory committees, from any & all claims, demands, actions & causes of action, which may result from participation in this program.

Influenza A and B are two types of influenza viruses that cause epidemic human disease. Influenza viruses are spread from person-to-person primarily through the coughing and sneezing of infected persons. Uncomplicated influenza illness is characterized by the abrupt onset of respiratory signs and symptoms which include, but are not limited to: fever, headache, nonproductive cough, sore throat, runny nose, body aches and excessive/abnormal fatigue. Among children, ear aches, nausea and vomiting are also commonly reported symptoms of the Flu Virus. Common reactions from the vaccination can include: soreness at the injection site, mild swelling, elevated body temperature, body aches and fatigue. These reactions typically begin 6-12 hours after the administration of the vaccination and can persist for 1-2 days thereafter.

Influenza Virus Vaccine 2020-2021 Formula: This vaccine contains noninfectious killed viruses & cannot cause influenza.
The Influenza vaccine should not be administered to persons known to have a severe (life-threatening) allergy to the following:
Chicken Eggs, Chicken Feathers and/or Chicken Dander

COMMUNICABLE DISEASES – HEALTH QUESTIONNAIRE & INFORMED CONSENT AGREEMENT

If you have been exposed to a communicable disease, you may cause the disease to spread to physicians, office staff, and/or other patients whom are in the practice. Therefore, prior to coming into our office, we are asking the following questions to reduce chance of transmission. Have you, your immediate family members, or any other persons in which you have had known, recent physical contact, tested positive for, or have been diagnosed as having COVID-19 or communicable diseases to the best of your knowledge?

____**Yes** ____**No** **If yes, when? Date:** _____

1. **A fever (above 100 degrees) in the last 14-21 days?** ____**Yes** ____**No**
2. **A cough, shortness of breath and/or difficulty breathing?** ____**Yes** ____**No**
3. **Persistent pain, pressure, or tightness in chest?** ____**Yes** ____**No**
4. **Experienced recent loss of senses, such as taste or smell?** ____**Yes** ____**No**
5. **Flu-like symptoms (GI upset, headache or fatigue)?** ____**Yes** ____**No**
6. **Traveled within 14 days to any region affected strongly by COVID-19?** ____**Yes** ____**No**
7. **Are you currently on any immunosuppressive medications/treatments?** ____**Yes** ____**No**

By signing this document, I indicate I have read and completely understand all of the information given to me in regards to the Influenza vaccination. I hereby give my consent to *Olympus Family Medicine* to administer the Influenza vaccination. Furthermore, I understand that while COVID-19 exposure is unlikely, I accept the risk of possible contact with any form of communicable diseases while in-office, and still consent receive the Influenza injection at *Olympus Family Medicine* today. I further understand that if the answer to any of the above questions is *yes*, I might be asked to reschedule today's Influenza vaccine appointment to another date.

Full Name: _____ Birth Date: _____
Print First *Print Last*

Patient Signature: _____ Date: _____
(***Please Note:*** *Legal Guardian Must Sign If Patient Is Under the Age of 18*)

Patient has read and understands all above information. **Influenza Vaccination Given:**

_____**Fluzone High Dose** 0.5ml, Sanofi Pasteur; Lot#(UJ310AB) Exp Date:(06/30/2020) has been given in _____Deltoid **(65+ yrs)**

_____**Fluzone Quadrivalent** 0.5ml, Sanofi Pasteur; Lot#(UJ286AA); Exp Date:(06/30/2020) has been given in_____ Deltoid **(3+ yrs)**

Administered By: _____ **Date Given:** _____