



MILE HI IMMUNIZATIONS, LLC
 283 Columbine Street #150, Denver, CO 80206
 303-374-3374 phone 303-374-8656 fax

2010 INFLUENZA CONSENT FORM

Patient MUST be 6 months or older to receive services

NAME LAST (one character per box)												NAME FIRST												MIDDLE INITIAL			
STREET ADDRESS																											
CITY																		STATE			ZIP						
SEX	DATE OF BIRTH						AGE			PHONE																	
M / F	M	M	/	D	D	/	Y	Y	Y	Y				-													

Precautions & Contraindications: Please Shade-In "Yes" or "No" for each question.

Have you ever had a flu shot before?..... YES NO

Are you currently receiving chemotherapy, radiation therapy or immunosuppressive therapy?..... YES NO

Do you have any known sensitivities to any components of Influenza virus vaccine? YES NO

Have you ever had an adverse reaction to another vaccine? YES NO

Please list the adverse reaction _____ YES NO

Do you have a past history of Guillain-Barre syndrome? YES NO

Do you have any history of hypersensitivity to chicken eggs or egg protein, chicken or feathers? YES NO

Do you have any hypersensitivity to any component of the vaccine, including thimerosal? YES NO

Do you have a history of sensitivity to latex? (refers to gloves and rubber stopper) YES NO

Do you currently have a fever or respiratory illness or any other type of infection? YES NO

BASED UPON YOUR RESPONSES TO THE ABOVE QUESTIONS, THE NURSE MAY REFER YOU TO YOUR PHYSICIAN FOR YOUR INJECTION.

I understand the adverse reactions associated with the Influenza vaccine and I am aware that a copy of the vaccine manufacturer's drug information sheet is available at the CDC website. Furthermore, I have also had an opportunity to ask questions about this immunization. I believe that the benefits outweigh the risks and I assume full responsibility for any reactions that may result. My medical record may be shared with my physician/insurance. I waive and release any and all claims I, or anyone claiming by or through me, now have or may hereafter acquire against Mile Hi Immunizations and the clinic site sponsor and their respective parent, subsidiaries, and affiliates, and each of their directors, officers, employees, and agents for any and all damages or injuries arising out of or related to the receipt of the flu shot, including, without limitation, if I, the person named below for whom I am authorized to make this request, contract Influenza, other respiratory diseases, or suffer any other damages or adverse reactions, including death, following administration of this flu shot. I am requesting that the immunization be given to me or the person named below for whom I am the legal guardian.

X _____ (Signature/Legal Guardian) Date: _____

For OBSERVATION: Please remain on the premises for 10 minutes following vaccination. If you leave the area, you are doing so against medical advice. Your safety is our primary concern.

THIS SECTION TO BE COMPLETED BY NURSE
 (Please note, if one of the following is NOT a clear choice, shot must be paid for at time of service):

Please Circle One: Customer Employee

Please Circle One: Cash Check Bill Company

SITE: LD / RD NURSE'S INITIALS: _____

LOT #: CLINIC DATE: / / 2 0 1 0