Influenza Screening & Consent Form

Please answer the following questions:

1. Have you ever had a flu shot?
   - YES  - NO

2. Are you over the age of 18?
   - YES  - NO

3. Have you ever had an adverse (allergic) reaction to a flu shot?
   - YES  - NO
   If so, please describe your symptoms to the nurse.

4. Are presently ill? (i.e. fever, cough with colored mucus)
   - YES  - NO
   If so, please describe your symptoms to the nurse.

5. Are you allergic to eggs or egg products?
   - YES  - NO

6. Have you ever had paralysis associated with Guillian-Barre Syndrome?
   - YES  - NO

7. FOR WOMEN ONLY-

   Are you Pregnant or Nursing?
   - YES  - NO

Please read the following statement:

I have read or have had explained to me the annual influenza vaccine information statement. I have had an opportunity to ask questions, which were answered to my satisfaction. I believe, understand and accept the benefits and risks of the influenza vaccine and request that it be given to me or the person for whom I am authorized to make this request. I hereby release HealthFax, Inc., and any associated company from any and all liability from or in anyway connected to receiving this immunization.

_______________________________  ______________________________ ___________
Print Name Here    Sign Name Here    Date

This section: HealthFax Staff Only

Date of Event:    Location of Clinic:

Staff Initials:    Vaccine Lot#:    Expiration Date:

Dosage: .5ml    Injection Site:  R. Deltoid    L. Deltoid
   (circle one)

Manufacturer:    Sanofi Pasteur:    GSK:    Novartis (Chiron):    CSL:
   (check one)