VaxAmerica
now it's easy!

CONSENT FORM TO RECEIVE

INJECTABLE INFLUENZA VACCINE

Consumer Name: First Name _____ Last Name _____

Date of Birth: Month __ Day __ Year ____ **Gender:** ☐ **Male** ☐ **Female** **Phone:** ___ – ___ – ____

Address: Number and Street _____ City _____ State __ Zip Code _____

Consent: I have been given a copy of the current Vaccine Information Statement published by the Centers for Disease Control and Prevention (CDC) and I have read the information about influenza and the vaccine. I have had an opportunity to ask questions, which were answered to my satisfaction. I understand the benefits and risks of flu vaccination as described and request that flu vaccine be administered to me or to the consumer named above for whom I am the legal guardian or for whom I hold a power of attorney to make healthcare decisions.

I acknowledge that the NuFactor dba VaxAmerica Notice of Privacy Practices has been made available to me.

NuFACTOR, Inc. dba VaxAmerica will use and disclose personal health information to treat me (or the consumer) and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care.

I, for myself, (or for the consumer named above for whom I am the legal guardian or for whom I hold a power of attorney to make healthcare decisions) and for my or the consumer's heirs, executors, personal representatives and assigns, agree that we will not hold NuFACTOR, Inc. dba VaxAmerica liable for any harm that may be caused by my (or the consumer) receiving flu vaccine, and waive any claim for damages that I, (or the consumer) (or anyone on either of my or the consumer's behalf) may have against NuFACTOR, Inc. dba VaxAmerica, its directors, officers, employees, or agents on account of any loss, injury, death or damage I or the consumer may suffer as a result of the administration of flu vaccine.

Signature: _____ **Print:** _____ **Date:** _____
[Signature of Consumer/Legal Guardian] [Name of Consumer/Legal Guardian]

	Questions	Yes / I don't know	No
1.	Do you have a moderate or severe acute illness with or without a fever?		
2.	For women, are you pregnant or expect to become pregnant during the month after your flu vaccination? If "yes", please check with your healthcare provider before receiving your vaccine.		
3.	Are you allergic to eggs or egg products?		
4.	Are you allergic to latex?		
5.	Are you allergic to thimerosal?		
6.	After receiving a vaccination in the past, have you ever had a serious reaction?		
7.	Have you developed a neurological illness (such as Guillain-Barré syndrome) after getting vaccinated?		
8.	Do you have any drug allergies? If the answer is "Yes", then please list below. _____		

(TO BE COMPLETED BY HEALTHCARE PROFESSIONAL)

☐ **I have denied this consumer to receive vaccination due to medical reasons.**

Date of injection: _____ **Manufacturer and Lot #** _____

Circle intramuscular vaccination site: **RA** – right arm or **LA** – left arm

Person reviewing form and administering vaccine: _____
Signature with licensure initials Print name with licensure initials

Report all post-vaccination adverse reactions regardless of whether or not you believe the events are caused by the vaccine to the Vaccine Adverse Event Reporting System (VAERS) listed on your copy of the Vaccine Information Statement. Although unlikely, should anyone have side effects from the vaccination please contact your physician for follow-up care.

Name of Clinic Site **Clinic ID#**