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VACCINATION CONSENT FORM

I am providing this consent form to Charis Physicians Housecalls in order that I may be given the influenza/ and or pneumonia/and or tetanus vaccination. I have read and understand the information I have received concerning the possible benefits and side effects of the influenza/pneumonia/tetanus vaccinations. I hereby acknowledge that, based on the information presented to me, I am eligible to receive the influenza pneumonia/tetanus vaccine on this date. I understand that no assurance can be given that the influenza pneumonia/tetanus vaccination will give me immunity from contracting any strain of influenza or pneumonia or tetanus. I hereby acknowledge that I have received a copy of the Vaccine Information Sheet on Influenza Pneumonia/Tetanus I release Charis Physicians Housecalls from any liability for giving me the influenza/ pneumonia/Tetanus vaccination. I accept responsibility for seeking medical attention for any problems associated with my receiving the vaccines.

If a question is not clear, please ask Charis Physicinas Housecalls Provider to explain it.

Please Print Name of Patient: _____

SIGNATURE of Patient or Authorized Agent :_____   DATE:_____

1. Is the person to be vaccinated sick today, cold or flu symptoms?   YES   NO   N/A
2. Are you pregnant or suspect you are pregnant?   YES   NO   N/A
3. Has the person to be vaccinated ever had a serious reaction   YES   NO   N/A   after receiving any
   vaccination in the past?

4. Has the person to be vaccinated ever had Guillain-Barre Syndrome YES   NO   N/A
   or active neurological disorder?

5. Does the person to being vaccinated have an allergy to chicken *eggs,* eggs products? YES   NO   N/A

_____

For Clinic Use Only

Influenza
Site/ Dose/ 0.5 ml given IM,   L   R   Deltoid   Mfg:_____ LOT:_____ Exp. Date_____

Influenza
Site/ Dose/0.5ml given IM,   L   R   Deltoid   Mfg:_____ LOT:_____ Exp. Date:_____

Pneumonia
Site/Dose/0.5ml given IM, L   R   Deltoid   Mfg:_____ LOT:_____ Exp. Date:_____

Tetnaus
Site/ Dose/ 0.5ml given IM,   L   R   Deltoid   Mfg:_____ LOT:_____ Exp. Date:_____

_____   _____
Signature and title of Person Administering the Vaccine   Date

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