12759 Q Street
Omaha, NE 68137
402.973.1933
KohllsWellness.com
mshepard@kohlls.com

Kohll's Rx

Influenza Vaccination Assessment, Release & Consent Form

The following information is to be completed by individual receiving the immunization.
Please print legibly.

Date_____/_____/_____ Corporation Name_____

Name_____ Date of Birth_____/_____/_____ Sex ☐ Male ☐ Female

Phone ( ) _____-_____**Home** Address_____City_____State____Zip_____

Are you a dependent of an employee? If yes, please list their name:_____

PLEASE CIRCLE THE ANSWERS TO THE FOLLOWING QUESTIONS:

1.	Have you ever had a severe reaction to any vaccine?	YES	NO
2.	Do you have any severe drug or food allergies?	YES	NO
	If yes, are you allergic to EGGS, CHICKEN OR CHICKEN FEATHERS?	YES	NO
	If yes, are you allergic to THIMEROSAL, NEOMYCIN OR GELATIN?	YES	NO
	If yes, are you allergic to POLYMYXIN B, KANAMYCIN OR GENTAMICIN?	YES	NO
	If yes, are you allergic to POLYSORBATE 80 OR FORMALDEHYDE?	YES	NO
3.	Do you have any substantial fever, diarrhea or vomiting?	YES	NO
4.	Are you allergic to latex?	YES	NO
5.	Women: Have you had a mastectomy?	YES	NO
6.	Women: Are you pregnant or nursing?	YES	NO

If you answered **YES** to any of the above, the healthcare professional will have to determine if this vaccine is right for you.

I have read the above information or have had the information explained to me. I have had a chance to ask questions and these have been answered to my satisfaction. I understand the benefits and the risks of the influenza vaccine and ask that the vaccine is given to me, or to the person named above for whom I am authorized to make this request. I accept responsibility for seeking medical attention for any problems with this vaccination. I accept responsibility for seeking medical attention for any problems with this vaccination. I authorize billing of this vaccination to my health insurance. If for any reason my insurance does not pay for the vaccination, I agree to pay the full amount of the procedure.

Signature_____Date_____/_____/_____

Please do not write below this line. To be completed by nurse personnel.

Vaccine Manufacturer	Lot#	Exp. Date	Dose Admin	Admin Site	Admin By
❑ AFLURIA QUAD ❑ FLULAVAL QUAD ❑ FLUCELVAX QUAD ❑ FLUAD QUAD ❑ _____		/ /	❑ 0.5ML ❑ 0.25ML	❑ LT DT ❑ RT DT ❑ RT THIGH ❑ LT THIGH	

Nurse: if payment was received at clinic, please list. **Check # _____ Cash amount: _____**