

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 <u>EGGS, CHICKEN OR CHICKEN FEATHERS?</u> | YES | NO |
| If yes, are you allergic to <u>THIMEROSAL, NEOMYCIN OR GELATIN?</u> | YES | NO |
| If yes, are you allergic to <u>POLYMYXIN B, KANAMYCIN OR GENTAMICIN?</u> | YES | NO |
| If yes, are you allergic to <u>POLYSORBATE 80 OR FORMALDEHYDE?</u> | YES | NO |
| 3. Do you have any substantial fever, diarrhea or vomiting? | YES | NO |
| 4. Are you allergic to <u>latex?</u> | 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
<input type="checkbox"/> AFLURIA QUAD		/ /	<input type="checkbox"/> 0.5ML	<input type="checkbox"/> LT DT	
<input type="checkbox"/> FLULAVAL QUAD			<input type="checkbox"/> 0.25ML	<input type="checkbox"/> RT DT	
<input type="checkbox"/> FLUCELVAX QUAD				<input type="checkbox"/> RT THIGH	
<input type="checkbox"/> FLUAD QUAD				<input type="checkbox"/> LT THIGH	
<input type="checkbox"/> _____					

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