Varicella (Chickenpox) CONSENT FORM

I have read the current information (printed copy or digital download) about the Varicella Vaccination, entitled ***VIS publication, per reference*** attached to this Agreement and made a part of this Agreement by this reference.

That I understand this vaccination is live or attenuated; that I understand the benefits as well as risks to me from receiving this vaccination; that I wish to receive the Varicella vaccination;

That, to the maximum extent permitted by law, I irrevocably, unconditionally and fully waive any claim for, and release and forever discharge The Shot Nurse-Memphis, P.C.; and their respective parent companies, subsidiaries, affiliated entities, successors and assigns; and all of their respective shareholders, directors, officers, members, employees, representatives, contractors and agents (collectively "the Organizers") from all actions, causes of actions, complaints, suits, debts, costs, claims, losses, damages and demands whatsoever, including injuries, disease or death (collectively "Damages"), which I, and anyone acting through, by or on my behalf, now has, or may have in the future, arising or alleged to arise in any way out of any cause, matter or thing relating to being vaccinated, regardless of the cause or blame, including, without limitation, any negligent acts or omissions of the Organizers or any of them; I further expressly agree that the waivers, releases and indemnities contained in this Agreement apply, without limitation, to negligent rescue operations, treatments or selection of medical personnel.

That, to the maximum extent permitted by law, I waive any statute, ordinance, regulation or requirement of any state to the effect that the general release herein does not extend to claims which I did not know or suspect existed at the time I signed this Agreement, which, if I had known, may have materially affected my decision to sign this Agreement; rather, I expressly agree that all such Damages are hereby waived and released to the maximum extent permitted by applicable law;

That if any court of competent jurisdiction finds any part of this Agreement to be invalid or unenforceable, the remainder of this Agreement will continue to be valid, binding and enforceable; that this Agreement will bind me and my family, heirs, administrators, executors, personal representatives and assigns and will benefit the Organizers and their successors and assigns; that this Agreement is the entire agreement between me and the Organizers relating to the Clinic; that this Agreement will be interpreted under the laws of the State of Tennessee, without reference to any choice of law principals and that any law suits or disputes relating to this Agreement will be brought only in the state or federal courts located in Shelby County, Tennessee; that I expressly and irrevocably consent to the jurisdiction of such Tennessee courts; that I did not receive any promise, representation, understanding or interpretation of any term of this Agreement as an inducement to sign this Agreement; and that no officer, employee, representative, contractor or agent of any of the Organizers is authorized to alter or vary the terms or provisions of this Agreement or to make any representations to the contrary.

That I was given ample opportunity before signing this Agreement, to ask the nurse, my doctor, my attorney and my other advisors questions and to clarify, to my complete satisfaction, any questions or concerns I may have had concerning the Varicella (chickenpox) vaccine or any term of this Agreement;

BY SIGNING BELOW, I ACKNOWLEDGE AND CERTIFY THAT I HAVE READ AND UNDERSTAND THE "CONSENT, RELEASE AND INDEMNITY AGREEMENT" FOR THIS VACCINATION, AND THAT I AM SIGNING IT VOLUNTARILY. IN ADDITION, I HAVE READ AND UNDERSTAND THE "HIPAA POLICY" PROVIDED BY THE SHOT NURSE.

Please answer the following questions.	Yes	No
Are you sick and/or have a fever today?		
Any allergies to medications, foods, latex **Neomycin*** or **Gelatin***? *contraindicated	*	
Are you currently taking any antiviral medications? (Zovirax, acyclovir) if yes, wait 24 hours/stop for 2 wks		
Have you received a blood transfusion or received blood products in the past year? *may require MD order		
Family history of congenital/hereditary immunodeficiency? Have active TB? *requires MD order	*	
Have you ever had a serious reaction after receiving a vaccination?		
Do you have cancer, leukemia, AIDS, or any other immune system problem? *contraindicated		
In the last 3 months: taken steroids, anticancer drugs, Aspirin therapy or had radiation treatments?		
For women: Are you breast feeding or pregnant? Last menstrual period:_____ ********It is NOT SAFE to get pregnant for 1 month (4 weeks) after receiving this vaccination. **********	*	
Have you received any vaccinations in the past 4 weeks?		

Print Name: _____Date of Birth:_____

Male ▫ Female▫ Married__ Single___widowed_____ Email address_____

Signature:_____ Phone #: _____

Site given	
RUE	LUE
RLE	LLE

Person administering vaccine:_____Date:_____

Lot#/Exp. Date_____ Manufacturer: _____

Service Location:_____ VIS date:_____