The Shot Nurse Influenza (FLU) CONSENT FORM and VACCINE ADMINISTRATION RECORD

Please check requested vaccine and answer questions pertaining to that vaccine:

☐ **Flu Shot** ☐ **Senior flu shot (ages 65 and older)** ☐**Egg free flu shot** ☐**FluMist**

	YES	NO
Have you ever passed out or become lightheaded after having blood drawn or receiving a shot?		
Have you had a previous severe/life threatening reaction to the flu shot?		
Do you have a severe egg allergy?		
Have you ever had Guillain-Barre' syndrome?		
Are you allergic to any of the following: Thimerosal, gentamicin, gelatin, phenol, or natural rubber latex?		
Are you sick today (fever>100.4, cough, chills, loss of smell or taste)?		
Have you taken any influenza antiviral meds in the past 48 hours? (example: Tamiflu)		
Are you under 18 years of age **and** taking Aspirin products?		
If you're age 2-49 and especially afraid of shots consider the FluMist Nasal spray vaccination.		
******* **FLUMIST ONLY** ******** **FLUMIST ONLY** ********* **FLUMIST ONLY** *********		
Are you on any immunosuppressive medications such as prednisone, chemo treatments, Humira or Enbrel?		
Do you have a history of Asthma? If so have you had a recent flare up requiring medication or inhalers?		
Do you have any immunosuppressive conditions such as leukemia, aids, or other immune system problems?		

I have read the current information (printed copy or digital download) about the influenza vaccine listed below and hereby give consent for the healthcare provider of The Shot Nurse to administer listed vaccine. I have read the provided VIS publication recommended by the CDC for requested vaccine and understand the risks and benefits associated with this vaccine. I authorize TSN and /or representatives to leave a message on my home or cell phone service about recommended vaccinations. Also, to discuss matters related to my account with agents representing The Shot Nurse. I certify that I am the person requesting the influenza vaccine and at least 18 years of age; the parent or legal guardian of the minor receiving listed vaccine; or the legal guardian of the person receiving listed vaccine.

I have never had a life-threatening allergic reaction to Influenza (Flu) vaccination, I am not allergic to Thimerosal (a preservative) and have no history of Guillian-Barre Syndrome. That I understand the benefits as well as risks to me from receiving this vaccination; and that I wish to receive the Influenza (Flu) 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.

I was given an 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 Flu vaccine or any term of this Agreement;

I understand each and every 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

Print Name of person receiving vaccine: _____Date of Birth:_____

Signature:_____ Phone #: _____Email_____
Male ▫ Female▫

Site Given:	
LD	LVL

RD	RVL
nasal	

Person administering vaccine:_____Date:_____

Lot#/Exp. Date_____Manufacturer:_____

Service Location:_____ VIS date:_____

Other Recommended Vaccine for your Protection

Please take a moment to see other vaccines recommended by the CDC. Circle any vaccines you want to add for your protection.

Pneumococcal vaccine: protects against pneumonia. Recommended for everyone over the age 65 and the following high-risk persons:

- Asthmatics
- Diabetics
- History of heart or lung disease
- Smokers
- History of pneumonia or other severe respiratory diseases

Add this vaccine today because I fall into one of these categories and have not received any Pneumococcal vaccine YES NO

I've had a Pneumococcal vaccine in the past but want to make sure I'm protected with the latest available vaccine. YES NO

TDAP/ Tetanus Diphtheria Pertussis: Recommended booster every 10 years for all adults and with each pregnancy for women. Added protection again Whooping Cough.

Do you want to add this vaccine today for full protection? YES NO

Shingles/ Shingrix: Age 55 and older, Shingrix is a 2 shot series, once now and another in 2-6 months. Protects against shingles.

I would like to add this vaccine today. YES NO

Specific for ages 9-45

Gardasil 9 3 shot series, one now, #2 in two months, # 3 four months after the second dose. An anticancer vaccine that protects against viruses that causes cancer of the cervix, neck, throat, colorectal and genitals.

Do you want to add this vaccine today? YES NO