ADVANCED URGENT CARE

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Flu Consent

Patient Name:_____ Date:_____

Please read and initial below prior to receiving your immunization.

_____I have seen and read the Vaccine Information Sheet for the Flu immunization.

_____I am not allergic to eggs.

_____I am not allergic to Thimerosol (a preservative).

_____I am not pregnant.

_____I have not had Guillain-Barre Syndrome.

_____I have not had a severe reaction from previous flu vaccines. Severe reactions would NOT include mild body aches, low fevers, mild headaches, tiredness, swelling and or redness at injection site that did not last more than 24-48 hours.

_____I give Advanced Urgent Care permission to give me the Flu Vaccine.

Patient Name Patient or Guardian Signature Date