



This form is PRIVATE PROPERTY OF TotalWellness!

NURSE'S BOX Event #: _____
Event Date: _____
Nurse's Full Name: _____
Injection Site (check applicable box):
☐ R Arm ☐ L Arm ☐ Other: _____
Check Applicable:
☐ Multi-dose Vial or ☐ Pre-filled Syringe
☐ Minor Participant (see Signature)
Vaccine Lot #: _____

INFLUENZA VACCINE INFORMATION, CONSENT & RELEASE FOR INACTIVATED VACCINE ("FLU SHOT")
Some people should not be vaccinated. Contraindications include severe allergy to eggs (vaccine influenza is grown in hens' eggs) or any other vaccine component (i.e., thimerosal, a mercury-containing organic compound widely used as a preservative in many biological products, including some vaccines and contact lens solutions) and having a moderate or severe illness with fever at time of vaccination (not including minor illness). **Talk to a doctor before vaccination** if you are allergic to eggs or other vaccine components, have ever had an allergic reaction to a flu shot or similar vaccine, or have ever developed Guillain-Barre syndrome, a severe paralytic illness. The vaccine is not approved for children under six months old and certain brands are only approved for certain ages. Note, if the immune system is compromised by illness at the time of vaccination, the body may not respond as it should to build up antibodies against the flu. **The most common side effect of the flu shot is soreness at the injection site**, which can last up to two days but does not usually affect an individual's ability to perform normal daily activities. However, there are rare cases in which recipients report persistent arm pain. Some people, usually children and others who have not been exposed to the influenza viruses before, may notice "mild" flu-like symptoms, such as fever, malaise, and muscle weakness, after receiving a flu shot. Symptoms usually start six to 12 hours after vaccination and can last up to two days. **Less common side effects include allergic reactions and Guillain-Barré syndrome (GBS).** Life-threatening allergic reactions, which usually occur immediately, are rare but possible in individuals allergic to any vaccine component. The 1976 Swine flu vaccine was associated with an increased incidence of GBS. Since then, the risk is estimated to be very low at 1-2 cases/million vaccinated, which is much less than the risk of getting the flu. **Note that, although very unlikely, should you have a severe allergic reaction to the flu shot, epinephrine may be administered and Emergency Medical Services may be called to the scene. Also, in the rare event a needle stick injury occurs, you may be contacted about recommended follow up procedures.**

REGARDING THE PERSON WHO IS TO RECEIVE THIS VACCINE (CIRCLE ANSWERS):

- | | | | |
|---|-----|----|-----|
| 1. Has he/she received a flu shot before? | YES | NO | |
| 2. Is he/she allergic to thimerosal, eggs or egg products? | YES | NO | |
| 3. Has he/she ever had an allergic or other serious reaction to a past flu or other vaccination? If YES, please explain: | YES | NO | |
| 4. Does he/she have any other severe allergies? If YES, please describe here. If allergic to latex, inform the nurse and check the vaccine package insert for latex presence (it may be present in certain packaging by certain manufacturers). | YES | NO | |
| 5. If female, is she pregnant? | YES | NO | N/A |
| 6. Is he/she currently feeling sick or feverish (not including minor illnesses)? | YES | NO | |
| 7. Has he/she ever had Guillain-Barre Syndrome? | YES | NO | |

I have received and read the Influenza Vaccine Information Statement and the TotalWellness Privacy Practices Notice. I have carefully reviewed this form and have had the opportunity to ask questions to my satisfaction prior to consent. I accept that services might be rendered in a non-private setting. I agree to remain and keep the minor, if applicable, at the event for at least 15 minutes after vaccination. I hereby consent to the administration of the influenza vaccine. Furthermore, I hereby release and forever discharge for myself/the minor, my/his/her heirs, executors, administrators and assignees, TotalWellness and their employees, owners and representatives, as well as my employer or other company involved with this event and their agents, contractors, representatives, employees, successors, assignees, governing bodies, and advisory committees from any and all claims, demands, actions and causes of action, which may result from receipt of this vaccination. I will communicate the information provided to me today about the vaccination to my/the minor's primary care provider if I/the minor has one.

RECIPIENT INFORMATION (PLEASE PRINT LEGIBLY or we may ask you to complete another form):

NAME: _____ EMPLOYER/COMPANY PROVIDING SHOTS: _____

LOCATION (Address/City/State) OF EVENT: _____

AGE (Participants should be at least 9 years old. We recommend those younger than 9 see their primary care providers since 2 doses are sometimes required): _____ GENDER: ☐ Male ☐ Female DATE: _____

SIGNATURE of Recipient OR Parent/Legal Guardian if recipient is a Minor (younger than 19 years old in Alabama or Nebraska, or younger than 18 years old in another state): _____

PRINTED NAME of Parent/Legal Guardian providing signature, if applicable: _____