TOTALWELLNESS

INFLUENZA VACCINE INFORMATION, CONSENT & RELEASE FOR **INACTIVATED VACCINE ("FLU VACCINE")**

NURSE'S BOX Event #: _____ Event Date: _____
Injection Site: ☐ Right Arm ☐ Left Arm ☐ Other: _____
Quad Vaccine Brand: ☐ GSK-FluLaval ☐ GSK-Fluarix
☐ Sanofi-Fluzone ☐ Seqirus-Afluria ☐ Seqirus-Flucelvax
0.5 mL of Vaccine from Lot #: _____
Nurse's Name & Title: _____

Some people should not be vaccinated. Contraindications include severe allergy to eggs (some 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 vaccine or similar vaccine, or have ever developed Guillain-Barré syndrome, a severe paralytic illness. Maintaining a relationship with a primary care physician with regular visits is an important step you can take to protect your health. The vaccine is not approved for children under six months old and certain brands are only approved for certain ages. **The most common side effect of a 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. **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. **Note that, although very unlikely, should you have a severe allergic reaction to the flu vaccine, epinephrine may be administered and Emergency Medical Services may be called to the scene.** Also, in the rare event that a needle stick injury occurs, you may be contacted about recommended follow up procedures.

ANSWER THE FOLLOWING QUESTIONS (CIRCLE ANSWERS):

1.	Is this your first flu vaccination?	YES	NO	
2.	Are you allergic to thimerosal, eggs, or egg products?	YES	NO	
3.	Have you ever had an allergic or serious reaction to a past flu or other vaccination? If YES, please explain:	YES	NO	
4.	Do you have any other severe allergies? If YES, please explain: NOTE: If allergic to latex, inform the nurse and check the vaccine package insert for latex.	YES	NO	
5.	If female, are you pregnant? TotalWellness will only administer preservative-free flu vaccines to pregnant women. Pregnant women should discuss the flu vaccine with their primary care provider prior to getting a flu vaccine.	YES	NO	N/A
6.	Have you been sick or had a fever above 101°F in the last 3 days? Not including minor illnesses.	YES	NO	
7.	Have you ever had Guillain-Barré Syndrome (a severe paralytic illness)?	YES	NO	
8.	Have you had a physical exam in the past 12 months?	YES	NO	

If you answer yes to questions 1, 2, 3, 4, 5, 6, or 7 please consult with your primary care physician prior to receiving an influenza vaccine.

I have received, as of the event date listed above, and have carefully read and fully understand the contents of the current Influenza Vaccine Information Statement available at https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.pdf 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 signing. I recognize that services may be rendered in an area with limited privacy. If I desire greater privacy, I will let my nurse know. I agree to remain at the event for at least 15 minutes after vaccination for supervision if this is my first flu vaccination or if requested by the nurse due to my medical history. I understand the benefits and risks of influenza vaccine and hereby consent and request that inactivated influenza vaccine be given to me. I understand that I will receive 0.5 mL of vaccine. I expressly waive, release and forever discharge for myself, my heirs, estate, executors, administrators, successors and assignees, Vaccination Services of America, Inc. d/b/a TotalWellness and its employees, owners and representatives, as well as my employer or any other company involved with this event and their agents, representatives, employees, successors, assignees, governing bodies, and advisory committees (collectively, "Releasees") from any and all claims, demands, actions and causes of action, now known or hereafter known in any jurisdiction throughout the world, on account of injury, death or property damage arising out of or attributable to my participation in this vaccination program, whether arising out of the negligence of TotalWellness or any Releasee or otherwise. I further agree to indemnify, defend and hold harmless the Releasees from any litigation expense, attorney fees, or claim for personal injury in connection with my participation in this vaccination program. I understand that the information collected and entered onto this form may be transferred to TotalWellness via an express carrier (UPS, FedEx, etc.). I consent to the transfer of my immunization data to the Immunization Information Systems and/or any applicable state immunization registry or similar immunization records. I understand that TotalWellness may provide my name/unique ID to the sponsoring company for participation and/or incentive purposes. I will share the information provided about my vaccination with my primary care provider.

First Name _____ **Last Name** _____

Date of Birth (mm/dd/yyyy) __ __ / __ __ / __ __ __ __ **Age*** __ __ **Phone Number** __ __ __ - __ __ __ - __ __ __ __

Sex: (circle) Male Female Prefer not to answer

Company: _____ **City:** _____ **State:** _____

Home Address: _____

Primary Care Physician Name (Optional): _____
Your primary care physician may be contacted if you have an adverse reaction to the flu vaccine. If you do not have a primary care physician you may leave blank.

Signature: _____ **Date:** _____

*Participants must be at least 19 years of age in Alabama and Nebraska and 18 years or older in all other states.
This form is the property of TotalWellness. The back of this form is intentionally left blank.

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