TOTALWELLNESS

HIGH-DOSE/ADJUVANTED INFLUENZA VACCINE INFORMATION, CONSENT & RELEASE FOR **INACTIVATED VACCINE ("FLU VACCINE")**

HIGH-DOSE/ADJUVANTED VACCINE
PARTICIPANT MUST BE 65 YEARS OLD OR OLDER

NURSE'S BOX Event #: _____ Event Date: _____
Injection Site: ☐ Right Arm ☐ Left Arm ☐ Other: _____
Vaccine Type: ☐ 0.5 mL Fluad Adjuvanted from PFS (Seqirus)
☐ 0.7 mL Fluzone High-Dose from PFS (Sanofi)
Vaccine from Lot #: _____
Nurse's Name & Title: _____

Some people should not be vaccinated. Contraindications include severe allergy to any vaccine component and having a moderate or severe illness at time of vaccination. **Talk to a doctor before vaccination** if you are allergic to any vaccine component, have ever had an allergic reaction to a vaccine, or have ever developed Guillain-Barré syndrome, a severe paralytic illness. **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. **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.	Have you received a flu vaccine before?	YES	NO
2.	Are you 65 years old or older?	YES	NO
3.	Have you ever had a serious reaction after receiving a vaccine? If YES, please explain:	YES	NO
4.	Do you have allergies to medications, food, a vaccine ingredient, or latex? If YES, please explain:	YES	NO
5.	Have you been sick or had a fever above 101°F in the last 3 days? Not including minor illnesses.	YES	NO
6.	Have you ever had Guillain-Barré Syndrome (a severe paralytic illness)?	YES	NO

If you answer yes to questions 3, 4, 5, or 6 please consult with your primary care provider 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.immunize.org/wp-content/uploads/vis/flu_inactive.pdf and the TotalWellness Privacy Practices Notice available at https://www.totalwellnesshealth.com/privacy-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 associated with 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. I will visit https://www.totalwellnesshealth.com/private/ir-opt-out and complete the applicable state opt out form if I wish to opt out of registry reporting and my state allows this option. 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*** ____ **Mobile Phone Number** ___-___-_____

Sex: (circle) Male Female Prefer not to answer

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

Home Address: _____

Home Address City: _____ **State:** _____ **Zip:** _____

Race: _____ **Ethnicity:** _____

Signature: _____ **Date:** _____

*Participant must be at least 65 years old to receive high-dose/adjuvanted vaccine.
This form is the property of TotalWellness. The back of this form is intentionally left blank.