Immunization Consent Form

Participants must be 18 years of age or older to receive a vaccination

Quest Diagnostics®
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PLEASE ANSWER THE FOLLOWING QUESTIONS

If you provide a yes response to any of the questions below: Please see your health care provider for vaccination

1. Are you moderately or severely ill today? (e.g. fever, respiratory illness) _____ ☐ Yes ☐ No
2. Have you ever had an adverse reaction to:
   - A previous dose of influenza (flu) or pneumonia vaccine? _____ ☐ Yes ☐ No
   - A previous dose of any other vaccine? _____ ☐ Yes ☐ No
3. Have you ever had:
   - Guillain-Barre Syndrome? _____ ☐ Yes ☐ No
   - Active, unstablized neurological disorder? _____ ☐ Yes ☐ No

FIRST NAME | LAST NAME | MI

ARE YOU A(N) ☐ EMPLOYEE ☐ NON-EMPLOYEE

SELF-IDENTIFIED GENDER ☐ MALE ☐ FEMALE

DATE OF BIRTH** MM / DD / YYYY

DAYTIME TELEPHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE

ETHNICITY /RACE

☐ AMERICAN INDIAN ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN ☐ HISPANIC/LATINO ☐ NATIVE HAWAIIAN ☐ WHITE/CAUCASIAN ☐ OTHER: _____

PLEASE READ CAREFULLY

It is important that your primary care physician be notified of all vaccinations you have received. Keep this information for your records and provide a copy to your primary care physician. If your state requires reporting of vaccination to the health department, the vaccination you received today may be reported to your state's health department.

A copy of the current Vaccine Information Statement can be found on the Center for Disease Control website: cdc.gov/vaccines/hcp/vis
Quest Diagnostics Notice of Privacy Practices is available at QuestDiagnostics.com/our-company/privacy/

VIS NPP

I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Quest Diagnostics and of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information. A current copy of the Vaccine Information Statement published by the Center for Disease Control for the vaccine which I am about to receive was made available to me, and I have had the chance to ask questions. I understand that serious injury or death can result from any vaccination and in consideration of receiving the vaccination, voluntarily assume the risk of and accept full liability for any and all injuries and death which may occur as a result of my vaccination and request that the vaccine be given to me. I hereby release Quest Diagnostics, my insurance carrier, and any other organization(s) associated with these vaccines, their affiliates, directors, officers, employees, successors and assigns from any liability arising from or in any way connected with my receipt of the vaccines. Information provided on this consent form may be submitted to my insurance carrier to seek reimbursement for my immunization.

Participant or Guardian Signature _____ Date _____

If I am age 65 or older, I acknowledge the CDC's recommendation to receive a 65+ vaccine. If no 65+ vaccine is available to me, I agree to receive the standard thimerosal free vaccine.

PARTICIPANT INITIALS

FOR MEDICAL STAFF USE ONLY

DO NOT WRITE IN THIS AREA

**If 65+ vaccine is available, it can only be given to individuals age 65 and older

INFLUENZA VACCINE ☐ THIMEROSAL FREE ☐ 65+

ARM ☐ RIGHT ☐ LEFT

ROUTE/SITE: Intramuscular

DOSE: 0.5 ml

MANUFACTURER/PRODUCT NAME

VACCINE LOT NUMBER

EXPIRATION DATE MM / DD / YYYY

CLINIC ID E

NURSE'S NAME (PLEASE PRINT) ☐ RN ☐ LPN ☐ NP

TODAY'S DATE MM / DD / YYYY

TIME OF ADMINISTRATION : ☐ AM ☐ PM

NURSE'S SIGNATURE (INK ONLY)

NURSE'S LICENSE NUMBER