BOULDER ENDOCRINOLOGY

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INFLUENZA VACCINE (FLU SHOT) CONSENT FORM

1. **Have you ever had an allergic reaction to flu vaccine?** **Yes or No**
2. **Are you allergic to eggs, or egg products?** **Yes or No**
3. **Do you have a history of Guillain-Barre Syndrome? (illness associated with the swine flu vaccine in 1976 characterized by fever, nerve damage, and muscle weakness)** **Yes or No**
4. **Are you allergic to thimerosal (a mercury-based preservative)?** **Yes or No**
5. **Are you allergic to latex?** **Yes or No**
6. **Do you feel ill today or do you have a fever?** **Yes or No**
7. **If you are female, are you pregnant? # Weeks_____** **Yes or No**

I hereby certify that the foregoing history is true and complete to the best of my knowledge and I have received and read the "Vaccine Information Statement" from the CDC, have had an opportunity to ask questions that were answered to my satisfaction, and do wish to receive the flu vaccination fully understanding the risks and the benefits. I hereby consent to the administration of the influena vaccine (flu shot). Furthermore, I hereby release and forever discharge for myself, my heirs, executors, administrators and assignees, Boulder Endocrinology PLLC and their employees, from any and all claims, demands, actions and causes of action, which may result from participation in receiving the influenza vaccine.

PATIENT INFORMATION AND CONSENT

LAST NAME:	**FIRST NAME:**	**MI:**	
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
PHONE:	**E-MAIL:**		
BIRTHDATE:	**AGE:**		
SIGNATURE:		**DATE:**	

FOR CLINIC USE ONLY

MANUFACTURER AND LOT#:	LOT #:
EXPIRATION DATE:	
SITE OF INJECTION: R / L **DELTOID**	
SIGNATURE AND TITLE OF VACCINE ADMINISTRATOR:	