



# Saint Alphonus

ADVANCED HEALING BEGINS HERE

Administered by:
Route: IM   Rt Deltoid   Lt Deltoid
Date Administered :
Vaccine: Influenza Virus Vaccine Dose: 0.50 ml
Lot #:
Expiration Date:

## 2009-2010 Corporate Vaccination Consent & Release Form

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_

The 2009-2010 Inactivated Influenza Virus Vaccine contains the following strains:

- an A/Brisbane/59/2007 (H1N1)-like virus
- an A/Brisbane/10/2007 (H3N2)-like virus
- a B/Brisbane/60/2008-like virus

### CONSENT:

I hereby acknowledge that I have received and read the information sheet entitled "Inactivated Influenza Vaccine – What You Need To Know" (**VIS date: 08/11/09**) for the inactivated flu vaccination shot. I wish to receive, and I have had an opportunity to ask questions.

Questions*: Please check Yes or No for each question	Yes	No
1. Do you have a severe egg allergy?		
2. Are you allergic to the preservative Thimerosal?		
3. Have you ever had a severe adverse reaction to a flu shot?		
4. Do you have an acute febrile (fever) illness today?		
5. Have you had Guillain-Barre Syndrome within 6 weeks after a previous flu vaccination?		
7. Do you have thrombocytopenia or any blood disorder that would prohibit a shot in your muscle?		
8. Women: Are you Pregnant?		

**\*\*Yes\*\* answers may disqualify you from receiving the flu shot.**

I understand the risks of receiving the inactivated influenza vaccine, and I acknowledge that I have freely chosen to assume such risks by signing this release and receiving this vaccine. Furthermore, I hereby release and forever discharge, for myself, my heirs, executors, administrators, and assignees, my employer, its subsidiaries and their directors, officers, employees, agents, representatives, successors and assigns, as well as the independent professional physicians and nursing staff retained by my employer in connection with the administration of the flu vaccine, from any and all claims, demands, actions, and causes of action which may result or arise from my receipt of this vaccine.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_