GLENDALE PEDIATRICS 2020-2021

Injectable Influenza Vaccine Consent Form for Adults

I hereby give my consent, voluntarily and of my own free will, to the staff of Glendale Pediatrics to give me an influenza vaccine. I have read and understand the sheet: *VIS Influenza Vaccine: What You Need to Know.*

I declare that I am over 18 years of age and under 65 years of age.

1) I am not allergic to chicken eggs.
2) I have not had Guillain-Barre Syndrome.
3) I am not sick with a fever or an active infection.
4) I am not allergic to thimerosal or other mercury compounds.
5) I am not allergic to gentamicin, neomycin, or other aminoglycosides.
6) I have not had other live vaccinations within the past 28 days (eg. MMR, varicella, yellow fever).
7) I have not had an allergy shot within the past 48 hours.

- I understand that while the risks associated with influenza vaccine are rare, possible complications include, but are not limited to: pain at the site of injection, muscle or nerve pain, headache, fever, paralysis, Guillain-Barre Syndrome (a type of paralysis), encephalitis or allergic reactions (including anaphylactic shock or death). I also understand that it is not possible to predict side effects or complications that could be associated with the vaccine.
- I understand that the vaccination is being given by the staff of Glendale Pediatrics. The owner and/or operator of the site, their officers, directors and employees expressly disclaim any responsibility with respect to the vaccination procedure. My consent is given with this knowledge and in consideration of the staff of Glendale Pediatrics giving the flu vaccine and I, for myself, my heirs, executors and assigns hereby agree to release the owner and/or operator of this site, and their officers, directors and employees, from any and all claims arising out of, in connection with, or in any way related to my receipt of this influenza vaccine.
- I further understand that I am fully liable for the cost of the vaccine and I agree to pay in full for the vaccine at the time it is administered**. I expressly waive any other rights I have or believe I may have for third party payment for this service, and agree to be bound by the group's policy as outlined above.**
- I agree to WAIT for 15- 20 minutes after receiving the vaccine.

Print Name _____ Parent DOB _____

Child's Name _____ Child DOB _____

Signature _____ Date _____

Date Given	Manufacturer	Vaccine lot #	Exp date	0.5 cc IM	Admin by
Amount paid		Method			
$50		check #	cc	cash	