Please PRINT LEGIBLY and PRESS FIRMLY

TODAY'S DATE: MONTH / DAY / YEAR

DAYTIME AREA CODE & PHONE NUMBER

LAST NAME

M F

FIRST NAME

BIRTH DATE

EMAIL ADDRESS

PLEASE SELECT ONE OF THE FOLLOWING GROUPS:

☐ EMPLOYEE ☐ SPOUSE ☐ DEPENDENT (AGE 18 AND OLDER) ☐ RETIREE ☐ CONTRACTOR

ADULT IMMUNIZATION SCREENING FOR INACTIVATED INFLUENZA VACCINES

PLEASE CHECK BOX EITHER YES OR NO

Are you UNDER 18 years of age? (Must be 18 years of age or older to participate)	☐ YES	☐ NO
Have you ever had an adverse reaction to the influenza (flu) vaccination or any other vaccines?	☐ YES	☐ NO
Do you have hypersensitivity to egg proteins (eggs or egg products) neomycin, polymyxin, betapropiolactone or Thimerosol (preservative in mulit-dose vial)?	☐ YES	☐ NO
Do you have a history of Guillain-Barre Syndrome (an illness with sudden muscle weakness) within 6 weeks of receiving an influenza vaccine?	☐ YES	☐ NO
Are you pregnant or suspect you might be, or a nursing mother? If yes, please initial the box indicating you have had a prior discussion about the influenza vaccination with your physician	☐	☐ NO
Are you moderately or severely ill today (fever, respiratory illness)?	☐ YES	☐ NO

IF YOU ANSWERED YES TO ANY OF THESE QUESTIONS, YOUR PHYSICIANS CONSENT MAY BE REQUIRED TO RECEIVE THE VACCINE.
The multi-dose vaccine vial used for this immunization contains Thimerosal. State law in CA, DE, MO, NY and WA prohibits vaccinating pregnant women with vaccine containing Thimerosal.

Vaccination Record: It is important that your primary care provider be notified of all vaccinations you have received. I acknowledge and agree to take the responsibility to provide a copy of this consent form to my primary care provider. Empower Health Services (EHS), LLC, is not a substitute for your physician's care.

Informed Consent / Authorization: I hereby consent to have EHS, LLC, and its assigned screening partners, to administer influenza vaccine to me. EHS's Notice of Privacy Practices (NPP) has been made available to me in connection with this Flu Immunization Program. A current copy of the NPP is also available at www.empowerhealthservices.com/privacypolicy. My signature below acknowledges receipt and acceptance of the NPP. I acknowledge I have received a copy of the Inactivated Flu Vaccination Information Sheet (VIS) 08/06/2021 for the vaccine I am receiving, and I have had a chance to ask questions. I understand that after receiving the vaccination, it is my responsibility to remain in the immediate area for 15 minutes in the event of an adverse allergic reaction. I understand that serious injury or death can result from any vaccination and in consideration of receiving the vaccination above, voluntarily assume the risk of and accept full liability for any and all injuries and death which may occur as a result my immunization. Should any reaction occur after I leave the program site, it is my responsibility to obtain medical treatment from my personal health care provider. I understand there is no assurance that the vaccine will prevent flu. I understand the benefits and possible side effects of the vaccine(s) and request that the vaccine(s) be given to me.

I release and discharge EHS, LLC, and their respective shareholders, parent, subsidiaries, officers, directors, employees, together with their respective affiliates, and the program sponsors, the owners/operators of this facility, my insurer, and/or administrative service provider/wellness program provider associated with this program from any and all liability, damages, claims or causes of action that may arise from my participation in this Flu Vaccination Program. This release shall be binding upon my heirs, assigns, executors, administrators and representatives.

Signature: _____ **Date:** _____

FOR MEDICAL STAFF ONLY, DO NOT WRITE IN THIS AREA

SITE CODE: 1056

☐ Bill Company

☐ Self Pay ___.___

☐ Cash

☐ Credit

☐ Check #_____

Influenza Vaccine:
Sequirus / Afluria - Quad.
LOT #: P100355218
EXPIRATION DATE: 06/16/22
Dose: 0.5 mL Route: IM

Site
☐ Right Arm
☐ Left Arm

TODAY'S DATE: ____/____/____

NURSE NAME & TITLE (PRINT): _____

GREGG A. KLING D.O.
Medical Director
Federal I.D. No. 36-4536723