PHYSICIANS QUALITY CARE
ACUTE ILLNESS AND INJURY

Flu Vaccine Consent Form

Please Circle Your Response

1.	**Have you had a flu shot before?**	**YES**	**NO**
2.	**Are you allergic to eggs?**	**YES**	**NO**
3.	**Are you currently taking any antibiotic for infection?**	**YES**	**NO**
4.	**Do you feel ill today or do you have a fever?**	**YES**	**NO**
5.	**If you are female, are you pregnant?**	**YES**	**NO**
6.	**Have you ever had Guillain-Barre Syndrome?**	**YES**	**NO**

I hereby certify that the foregoing history is true and complete to the best of my knowledge, and I request the flu vaccine. I understand the benefits and risk of influenza vaccine, and ask that the vaccine be given to me. I have been provided the opportunity to receive a copy of the "Notice of Privacy Practices" that explains when, where, and why my confidential health information may be used or shared. I acknowledge that Physicians Quality Care (PQC), the physicians, nurses, and PQC staff may use and share my confidential health information with others to treat me, in order to arrange for payment of my bill and for issues that concern PQC's operations and responsibilities.

Patient Receiving Vaccine

First Name | **Middle Name** | **Last Name**

Signature | **Date** | **Date of Birth** | **Age**

If person receiving the Vaccine is under 18 Years of Age

Parent or Legal Guardian Signature | **Date**

CLINIC USE ONLY

Brand | **Lot#** | **Exp. Date**

Injection Site | **Date First Injection** | **Initials**

Injection Site | **Date Second Injection** | **Initials**