KAISER PERMANENTE® thrive

Influenza Vaccination Consent & Record

Please complete ALL information below. Unless otherwise authorized, we will use it only to (1) contact you if there is a problem with the vaccine and/or (2) update your Kaiser Permanente medical record if you are a Kaiser Permanente member.

Are you a Kaiser Permanente Member? ○ No ○ Yes - ***Enter your Medical Record No. below***

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____

Name (Print)			**Birthdate:**
Last:	**First:**	**Middle Initial:**	**Month Day Year**

Home address (Print)

Street: **City:** **State:** **Zip Code:**

Company/Site	**Day Phone Number**	**Gender (circle one)**
		M F

Check any of the conditions below that apply to you.

If any apply, then you are not eligible to receive a flu shot today. You should discuss vaccination with your physician first.

- ○ Allergic to eggs or egg products.
- ○ Adverse reaction to prior flu vaccination.
- ○ History of Guillain-Barre Syndrome.
- ○ **I HAVE NONE OF THESE CONDITIONS.**

Check any of the conditions below that apply to you.

If any apply, then consult with the nurse who will advise if you should have a flu vaccination today.

- ○ Fever due to current illness.
- ○ Current active illness, like upper respiratory infection or other illness.
- ○ Allergy to latex
- ○ **I HAVE NONE OF THESE CONDITIONS.**

For women - are you pregnant or suspect you may be pregnant? ○ YES ○ NO

Consent and Release of Liability - ***Please Read, Sign & Date***

I understand that common reactions to flu vaccinations include soreness around the injection site, fever, chills, headache and tired, achy feeling. If soreness lasts more than two days, I understand that I should notify my doctor. I agree that I will seek medical attention immediately if I have an allergic reaction, including shortness of breath, rash or swelling of the lips or tongue. I understand that a vaccine can possibly cause serious problems, such as severe allergic reactions, though the risk of a vaccine causing serious harm, or death, is extremely small. A copy of the Vaccine Information Statement version dated August 15th 2019 has been made available to me, and I have had a chance to ask questions. In consideration of receiving the flu vaccination I assume the risk of and accept full liability for any and all injuries, including death, and request that the vaccine be given to me. I hereby release Kaiser Permanente (including Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan, Inc., Northern California Region; Kaiser Foundation Health Plan, Inc. d/b/a KP Workforce Health Services; Kaiser Foundation Hospitals; Kaiser Permanente Insurance Company) and any other organization associated with the administration of my vaccination today, their affiliates, directors, officers, employees, successors and assigns, from any liability arising from or in any way connected with my receipt of the vaccine.

_____ _____

Signature **Date (required)**

FOR NURSE TO COMPLETE

► Flu Vaccine 0.5 mL dose given I.M. in Deltoid (check one): ○ Right ○ Left

► Manufacturer's Name: _____ Lot #_____

► Nurse's Name (print): _____ **Date**: _____ / _____ / _____

FOR KAISER PERMANENTE ADMINISTRATIVE USE ONLY

Entered Into Medical Record (KIDDS / HealthConnect) Date: _____ / _____ / _____ Initials: _____