GE Family Wellness Center Pharmacy

Managed by TriHealth

Flu Vaccination Consent Form

2020-2021 Flu Season

Name (please print clearly): _____

Home Phone: _____ Date of Birth: _____ Gender: Male/Female

Primary Care Physician (first and last name): _____

*****Please circle *ONE* of the following four options:*****

GE Employee	GE Retiree	GE Spouse or Dependent	GE Contractor
Please provide SSO Number: _____	Are you over 65 yrs? YES NO If >65yrs, what is your Medicare ID: _____	Are you on GE Benefits? YES NO *If spouse or child NOT on GE benefits, cost is $29 and payable by cash or check.	*If Contractor, cost is $29 and payable by cash or check.

Please answer the following questions:

1. Are you 16 years of age or older?	YES	NO
2. Do you currently have a fever or any type of infection?	YES	NO
3. Are you allergic to eggs, chicken, or egg products?	YES	NO
4. Do you have an allergy to latex or gelatin?	YES	NO
5. Have you ever had a reaction to a vaccine in the past that required medical treatment?	YES	NO
6. Have you ever had Guillian-Barre Syndrome (a severe paralytic illness)?	YES	NO
7. Have you had a bone marrow transplant in the past 6 months?	YES	NO

I have truthfully answered all of the questions on this form. I have also received a copy of the Vaccine Information Statement. My signature below indicates my permission for the vaccine to be administered to me.

Patient Signature: _____ Date: _____

Do not write below this line

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Pharmacy Use Only

Administrator: _____ Date: _____

Admin Site/Type (circle): [Left / Right] IM – Deltoid

Fluzone® Quadrivalent 0.5 ml - NDC: 49281-0420-50 - Lot: - Exp: