IMMUNIZATION CONSENT & RELEASE FROM LIABILITY FOR INACTIVATED SEASONAL INFLUENZA VACCINE ("FLU SHOT")

Check: Staff ☐ or Student ☐ Name of School _____ Home Room Teacher _____
NAME of PERSON RECEIVING vaccination _____
Date of Birth ____/____/____ Age _____ Male ☐ Female ☐
Street Address _____ City _____ State _____ Zip _____
(If <18 yrs) Name of Parent(s)/Legal Guardian _____
Emergency Contact _____ Phone # _____
BCBS Policy ID # (Employees ONLY, if applicable) _____

THE SEASONAL INFLUENZA VACCINE ("Flu Shot") is an inactivated (killed) vaccine, also known as the "flu shot" which is administered by injection with a needle into the muscle (most commonly the Deltoid). **Read the attached Vaccine Information Statement (VIS)** titled **"Influenza Vaccine Inactivated, What You Need to Know "**, developed by the Centers for Disease Control and Prevention **prior to completing consent to receive the vaccine to help you decide whether the vaccine is appropriate for you or your child. If you question whether or not you should receive the flu vaccine, you should contact your personal health care provider.** Your signature below testifies that you received and have read the **VIS** for the **Inactivated Influenza vaccine** and understand all of the risks and benefits related to vaccination. Students are required to remain in the area for observation **15 minutes**.

1. Do you have allergies or reaction to **eggs, gelatin, thimersol, mercury, sulfites, or latex**? YES ☐ NO ☐
2. Do you currently have a moderate or **severe acute infection or fever**? YES ☐ NO ☐
3. Have you ever had a severe **allergic reaction or anaphylactic reaction** to a flu vaccine? YES ☐ NO ☐
4. Do you have a **blood clotting disorder, take aspirin, or aspirin containing medications** daily? YES ☐ NO ☐
5. Have you **received any other vaccines or shots** within the past 4 weeks? If yes, list on back. YES ☐ NO ☐
6. Have you ever had a **seizure, brain/nervous system problems or Guillian-Barre Syndrome**? YES ☐ NO ☐

If you circled "**YES**" to any of these questions **OR** if there is a **known contraindication to any of the allergies listed**, further questioning is warranted and the "flu shot" may not be given.

WAIVER AND RELEASE I hereby release and forever discharge and hold harmless the state of Mississippi, Home Care Plus, Inc., Florence Family Clinic, WellnessWorks, River Oaks Hospital, Brandon Discount Drugs, CarePlus Clinics, MedImmune, Novartis, the Rankin County School District and its Superintendent of Education and trustees, and all other employees, agents, or those representing the school district and its directors, officers, employees, agents and assigns, any retail site, grocery store, pharmacy, corporation, physician and/or medical director and their respective directors, officer, employees, agents and assigns (hereinafter, collectively referred to as "Releasees") from any and all liability, claims, demands, and causes of action of whatever kind of nature, either in law or equity, which may hereafter arise from my receipt of the flu vaccine. I understand and acknowledge that this Consent and Release discharges Releasees from any liability or claim that may arise as a result of my receipt of the flu vaccine, with respect to any bodily injury or other injury, including any mental injury, illness, death, or property damage that may result. I understand that Releasees do not assume any responsibility or obligation to provide financial assistance or other assistance, including, but not limited to medical, health, or disability insurance, in the event of injury, illness, death or property damage, unless otherwise expressly governed by and interpreted in accordance with the laws of the State of Mississippi. I agree that in the event that any clause or provision of this Release shall be held to be invalid by any court of competent jurisdiction, the invalidity of such clause or provision shall not affect the remaining provisions of this Consent and Release.

INFORMED CONSENT AND HIPAA PRIVACY INFORMATION I have read the above Consent and Release and understand its provisions and applicability and have been given the option and recommendation of consulting with my own personal physician. I understand that participating in the flu vaccination program is totally voluntary and that neither I nor my child is required to participate. I understand the benefits and risks of the flu vaccine as described and request that the vaccine be given to me or the person named above for whom I am the legal guardian. My medical record may be shared with my physician and/or insurer on a need to know basis. I understand that the company providing the vaccination will use and disclose my personal health information to treat me, to receive payment for the care it provides me, and for other health care operations, which generally include activities to improve the quality of care. I hereby freely and voluntarily, without duress, execute this Consent and Release under the above written terms.

_____ ____/____/____
SIGNATURE (Parent/Legal Guardian or Adult Patient) Date

PAYMENT: ☐ Cash or ☐ Check # _____ in the amount of $28.00 OR _____ or ☐ Other _____

FOR CLINICIAN USE ONLY: (VIS STATEMENT: PROVIDED AT TIME OF VACCINATION)

Vaccine Name Fluarix Manufacturer GCK Biologicals
Lot # H4297 Expiration Date 06 / 30 / 2024

Route: 0.5 ml inactivated influenza vaccine given by Intramuscular injection to the following site
RIGHT Deltoid _____ or LEFT Deltoid _____ Without Difficulty or Complications (Report problems on back)

____/____/____ _____
Date of Administration Vaccinator Signature/Title