JBS Flu Vaccination Clinic

9 am to noon, Thursday, September 12
Noon to 3 pm, Tuesday, October 15

Only the injectable influenza vaccine, Quadrivalent, will be available.

If you are interested in reserving the vaccine for your student(s), contact Casie Tomlinson, school nurse.

IMPORTANT: Students must turn in a signed permission slip at the time the vaccine is administered. For more information and permission slips, scroll to the second page.

The cost of the vaccine ($30) will be storecarded.

Choice
Flu Vaccinations, LLC

Influenza Vaccination Consent and Release Form

Please provide information for individual receiving vaccine.

Last Name	First Name	MI	Age	DOB

Street Address	City	State	Zip

Phone Number	Email Address	Physician Name (if under 18 years old)

Please read the questions below, if you answer **yes** to any of them please discuss with your vaccine administrator.

The information you provide is private and confidential and will not be used for any other purpose.

Questions for discussion (please check appropriate boxes)

1. Do you currently have an acute feverish illness? ☐Yes ☐No
2. Have you been vaccinated against the flu in previous years? ☐Yes ☐No
3. Have you experienced any significant problems after vaccination? ☐Yes ☐No
4. Are you **severely** allergic to eggs, egg products, or gelatin? ☐Yes ☐No
5. IF UNDER 9 YEARS OF AGE: Have you received 2 doses of flu vaccine before July 2017? ☐Yes ☐No
6. FOR WOMEN: Are you pregnant or breastfeeding? ☐Yes ☐No
7. Do you have a history of Guillain-Barre Syndrome (temporary severe muscle weakness)? ☐Yes ☐No
8. Do you have a Thimerosol or Latex allergy? ☐Yes ☐No

If you answered yes to any question above, please specify _____

VACCINE ADMINISTRATION CONSENT and RELEASE

I have read or have had explained to me the information provided about Influenza and the Influenza vaccine. I have had an opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the Influenza vaccine and request that the vaccine be given to me or to the person named above for whom I am authorized to sign. I hereby release *Choice Flu Vaccinations, LLC* from any and all liability associated with the administration and potential side effects of the vaccine.

Signature: _____ Date: _____

ADMINISTRATIVE USE ONLY

Vaccine	**Site**	**Manufacturer**	**Lot #:**
☐ IM (from 10 dose vial 0.5mL) ☐ IM Pediatric Preservative-Free 0.25mL ☐ IM Adult Preservative-Free 0.5mL	☐ Left Deltoid ☐ Right Deltoid ☐ Left Thigh ☐ Right Thigh ☐ Other _____	☐ GSK ☐ Seqirus ☐ Sanofi Pasteur ☐ Novartis	**Expiration Date:**

Signature of Vaccine Administrator _____

Date Vaccination Given _____