Wellness2000, Inc.
Corporate Wellness • Health Risk Management • Employee Assistance

# INFORMED CONSENT FOR VACCINATION

***I request the checked vaccine be given to me or the person named below for whom I am authorized to sign. I have been given and have read the Center for Disease Control information for each vaccine, and I understand the benefits, side effects, and risks of the vaccine as described. I release and hold harmless Wellness 2000 Inc. private companies, and community clinics from all risks and damages related to this flu vaccination that is provided to me voluntarily. I understand that I am responsible if payment is denied by my insurance carrier.***

**PLEASE PRINT**

Last Name _____ First _____ MI _____ DOB: M ___ / D ___ / Y ___ Sex/Gender _____

Mailing Address _____ City _____ State _____ Zip _____

( ) _____ Phone Number

Employer: Southern Oregon University

**X** _____ **Signature of Person to Receive Vaccine (or Parent/Guardian)**

_____ **Date**

**Influenza (Flu): $** _____ **Email:** _____

**PLEASE SELECT PAYMENT METHOD**

☐ Cash ☐ Check: Ck #:_____ ☐ Visa/MC # _____ Exp. Date: _____

Provide copy of insurance card(s) **or** fill in:

Insurance Carrier: _____ Insurance ID# _____ Group #_____

Deductible and/or Coinsurance payments may apply

**Please check (☑) if the person receiving immunization:**

☐ Has had flu vaccination in past years with no adverse reactions.

- ☐ Has a severe allergy to eggs.
- ☐ Has ever had a serious allergic reaction or other problem after getting a vaccine.
- ☐ Is currently pregnant or planning pregnancy within 3 months.
- ☐ Has a history of Guillain-Barre Syndrome.
- ☐ Never has had this vaccine before (wait 10 minutes after injection).

Result: ☐ No adverse reaction ☐ Reaction (document on back) ☐ Left without checking back

**SERVICES ADMINISTERED:**

☐ **Aflura Flu** CPT 90688
Manufacturer: Seqirus Lot #
Exp. Site: R L Deltoid

☐ **Fluad High Dose Flu** CPT 90964
Manufacturer: Seqirus Lot #
Exp. Site: R L Deltoid

RN:_____ Date:____/____/ 2023

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