# Flu Vaccine Consent Form

KASSAY
FAMILY MEDICINE

**Last Name** **First Name** **MI**

Yes No 1. Have you ever had a flu vaccination?

Yes No 2. Do you have or have you ever had allergies or a serious reaction to vaccines, medications, eggs or the preservative thimerosal?

If yes, please list: _____

Yes No 3. Do you have a fever or are you feeling ill today?

Yes No 4. For Women: Is it possible you could be pregnant or are you lactating?

***2020-2021 Flu Season Drive Through Clinic:** We do advise waiting 15 minutes after your vaccine shot before driving. There is a chance you may experience light-headedness or fainting following routine injections.

I have read, or had read to me, the written information regarding the vaccine I quested. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine being administered and have received a copy of the Vaccine Information Statement. I, on behalf of myself, my heirs, executors personal representatives, agents, successors, and assigns hereby agree to release, indemnity, and hold harmless Dr. Kara Kassay, and employees from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccine requested. I understand that the information contained on this form may be shared with the State Health Department and State Immunization Registries, and will remain confidential and will not be released without my consent. If eligible, I ask that payment of authorized Medicare benefits be made on my behalf to Kara M Kassay, M.D, P.C. for the immunization administered to me. I am authorizing any holder of medical or other information about myself to be released to Centers for Medicare and Medicaid Services and its agents, including any information needed to determine any and all benefits for related services. **If my insurance denies payment then I will be responsible for payment.**

Signature of Patient or Guardian Date

Printed Name of Patient or Guardian Relation to Patient

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