Where the Garden Grows
Medical Clinic

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Phone 623-594-6400 • Fax 623-930-4822

INFLUENZA VACCINE CONSENT FORM

Please mark YES or NO for each question	YES	NO
1. Are you allergic to eggs or egg products?		
2. Have you ever had a serious reaction to a previous dose of flu vaccine?		
3. Do you have a history of Guillain-Barre Syndrome?		
4. Are you pregnant?		

Patients under 9 years of age who are receiving the flu vaccine for the first time will require a booster in 30 days.

I hereby certify that the foregoing history is true and complete to the best of my knowledge and I have received and read the "Vaccine Information Statement" from the CDC, have had an opportunity to ask questions that were answered to my satisfaction, and do wish to receive the flu vaccination fully understanding the risks and the benefits. I hereby consent to the administration of the flu vaccine. Furthermore, I hereby release and forever discharge for myself, my heirs, executors, administrators and assignees, Where the Garden Grows, PLC and their employees, owners and representatives. I understand that my information shall be held strictly confidential. ***I understand Where the Garden Grows, PLC is not affiliated with Great Destinations Pediatrics.*** Insurance/Medicare will not be billed; however, forms/receipts are available for reimbursement. DO NOT SIGN THIS FORM IF YOU HAVE ANY QUESTIONS.

PARTICIPANT INFORMATION AND CONSENT

LAST NAME:	**FIRST NAME:**		**MI:**
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
PHONE:	**E-MAIL:**		
BIRTHDATE:	**AGE:**		
SIGNATURE (patient, parent or legal guardian):		**DATE:**	
WITNESS SIGNATURE:			

FOR CLINIC USE ONLY

MANUFACTURER: Sanofi Pasteur	**LOT#**
EXPIRATION DATE:	
Route of Administration: IM	
SIGNATURE AND TITLE OF VACCINE ADMINISTRATOR:	