

Client Consent for Flu Shot

Flu Shots by Nurse Janet, Inc.

By my signature below, I acknowledge:

I have read or had explained to me information about risks and benefits of the vaccination and:

- **I have no history of Guillain-Barre syndrome.**
- **I have no prior history of any neurological symptoms following a flu shot.**

And, I, the undersigned, on behalf of myself, my heirs, personal representatives and assigns, do hereby fully and forever waive and release the sponsor and the provider corporation, their officers, directors, employees, and agents from any and every claim, loss, liability, demand, action and damage whatsoever resulting from or arising out of my participation in this clinic.

**PLEASE BRING COMPLETED FORM TO YOUR FLU SHOT CLINIC
and a copy of the front of your insurance card**

Insurance Plan: REGENCE/ UNIFORM

KAISER of WA

PREMERA BLUE CROSS

MEDICARE

Primary Member ID #:		Group #:	
Medicare # (if applicable)			
First Name:	Last Name:		MI.:
Date of Birth (M / D / Y): / /		Male <input type="checkbox"/>	Female <input type="checkbox"/>
Subscriber Mailing Address:			
City:	State:	Zip Code:	
Phone #:			

For those insured under member's policy – also fill out the following:

Your Member ID #:		Group #:	
First Name:	Last Name:		MI.:
Date of Birth (M / D / Y): / /		Male <input type="checkbox"/>	Female <input type="checkbox"/>

Patient Signature:	Relationship to Member:
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For Office Use Only:

Administered by: Janet Parker

Date Given: _____

Mfr.: _____

Lot #: _____

Exp. Date: _____

Business Name: _____

Location: _____