



**Parker County
Hospital District**

**1130 Pecan Street
Weatherford, Texas 76086
817-599-1229**

Clinic Location: _____ Clinic Date: _____

Patient Name: _____ Birth Date: _____

Address: _____ City/ State/ zip _____

Phone: () _____ Alt. Phone: () _____

BEFORE getting an **Influenza** vaccine please check YES or NO to the following questions:

Did the person receiving the shot today receive the flu vaccine in 2010– 2011? Yes No

Have you received the seasonal Flu vaccine before? Yes No

Are you pregnant or breast feeding? (If yes, you will need permission from your doctor to receive the flu vaccine) Yes No

Do you have fever today? Yes No

Do you have an allergy to chicken eggs, egg products, or latex? Yes No

Is the person to be vaccinated have cold or flu symptoms today? Yes No

Have you ever had a neurological disorder or have you been diagnosed with Guillain– Bare’ Syndrome? Yes No

Do you have any health problems or allergic disorders that requires you to currently see a physician? Yes No
If yes explain _____

Do you have a known allergy to thimerosal, a derivative of mercury? (i.e. merthiolate, eye contact solution) Yes No

Has the person receiving the vaccination had a severe reaction after receiving any vaccinations? Yes No

I am providing this consent form to Parker County Hospital District in order that I may be given the influenza vaccination. I have read and understand the information I have received concerning the possible benefits and side effects of the influenza vaccinations. I hereby acknowledge that based on the information presented to me, I am eligible to receive the influenza vaccine on this date. I am feeling well today and I have not recently had fever. I understand that no assurance can be given that the influenza vaccination will give me immunity from contracting any strain of influenza. I hereby acknowledge that I have received a copy of the Vaccine Information Sheet on the 2011-2012 Influenza . I release Parker County Hospital District, its employees, representatives and agents from any liability for giving me the influenza vaccination. I accept responsibility for seeking medical attention for any problems associated with my receiving the vaccine. I have had the opportunity to have all my questions answered.

Signature: _____
Date: _____



Consent for Immunization of a Minor: I, (parent) _____ give permission and consent for (child) _____ DOB ___/___/_____ to receive the 2011 Seasonal Influenza Vaccine.

Mother Maiden Name: _____

Parent

Signature: _____ **Date:** ___/___/___

Staff Signature: _____ **Date:** ___/___/___