

Form Section 1: Personal Information (PLEASE PRINT)

Last Name:	First Name:
Home Address:	
Date of Birth:	Age Male <input type="checkbox"/> Female <input type="checkbox"/>
Daytime Phone Number:	Employer: Insurance Provider:
Are you covered by this company's insurance plan? YES <input type="checkbox"/> NO <input type="checkbox"/>	
If "YES", is it your PRIMARY insurance? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Write Insurance Member ID as it appears on your insurance card below: (NOT GROUP #)	

NOTE: We DO NOT accept Medicaid, Medicare, or SECONDARY Anthem, Humana, or MMOH plans!

Section 2: Please mark the corresponding boxes that apply to you:

1. **Pre-Immunization Conditions:** For your protection, you must accurately respond to each question in this section:

- Yes No Do you suffer from sensitivity or allergy to egg, egg products, or thimerosal (a mercury derivative used as a preservative)?
- Yes No Do you currently have an elevated body temperature (fever), acute respiratory or other active infection or illness?
- Yes No Are you currently on antibiotics or steroids for an active infection?

2. **Personal History:** Has a physician or healthcare provider ever told you that you have or had any of the following conditions?

- Yes No Guillain-Barre syndrome -a neurological disorder causing temporary paralysis?
- Yes No A tightening in your throat, inability to breathe, or an allergic reaction immediately following a previous vaccination?

Section 3: Consent

Consent for vaccination: The most common reactions may be a sore or tender arm at the injection site, or possibly fever, chills, headache, or muscle aches. Symptoms usually last from 24-48 hours. I release HealthWorks and its affiliates from responsibility of any reaction resulting from the injection, and I take full responsibility to seek medical attention should more severe symptoms occur. I acknowledge I have no condition including, but not limited to, those listed in Sections 1 & 2 above that would prevent me from receiving an influenza vaccination at this time.

I have read, or had explained to me, the CDC's Vaccine Information Statement (VIS) for the seasonal flu vaccine and understand the risks and benefits.

I give consent to HealthWorks and its staff to administer the 2024-2025 Seasonal Influenza Vaccine to me.

Signature:	Date:
Parent/Guardian Signature if under 18:	

Injection Site: Nurse Only (circle/initial)

The 2024-2025 quadrivalent vaccine contains the following strains:

- an A/Victoria/4897/2022 (H1N1)pdm09-like virus;
- an A/Thailand/8/2022 (H3N2)-like virus; and
- a B/Austria/1359417/2021 (B/Victoria lineage)-like virus.
- a B/Phuket/3073/2013 (B/Yamagata lineage)-like virus.

Left

Right