

**HealthWorks 2025-2026 Influenza Vaccine Consent**

**Section 1: Personal Information (PLEASE PRINT)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Last Name: | First Name: | | | | |
| Home Address: | | | | | Male  Female |
| Date of Birth (mm/dd/yyyy): | | Age: | | Daytime Phone: | |
| Employer: | | | Insurance Provider: | | |
| Are you covered by this company’s insurance plan? Yes  No | | | | | |
| If you answered “yes” above, is it your PRIMARY insurance? Yes  No | | | | | |
| **REQUIRED: Insurance Member ID** as it appears on your insurance card: | | | | | |
| ***NOTE: We DO NOT accept Medicaid, Medicare, or SECONDARY Anthem, UHC, or MMOH plans!*** | | | | | |

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

1. **Pre-Immunization Conditions:** Please 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? |

1. **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 for Vaccination**

|  |  |
| --- | --- |
| I understand that common side effects of the vaccine can include arm soreness, fever, chills, headache, or muscle aches, typically lasting 24–48 hours. I release HealthWorks and its affiliates from liability for any reaction and will seek medical care if severe symptoms occur. I confirm I have no conditions listed in Sections 1 & 2 that would prevent me from receiving the flu vaccine. **I have read or been informed of the CDC’s Vaccine Information Statement and understand its risks and benefits and consent to receiving the flu vaccine:** | |
| Signature: | Date: |
| Parent/Guardian Signature if under 18: | |

**Injection Site: Nurse Only**

(Circle/Initial)

**Left**

**Right**

The 2025-26 trivalent vaccine contains the following strains:

* A/Victoria/4897/2022 (H1N1)pdm09-like virus;
* A/Croatia/10136RV/2023 (H3N2)-like virus (new for 2025-2026); and
* B/Austria/1359417/2021 (B/Victoria lineage)-like virus