VACCINE CONSENT FORM Aetna ID # W

First Name:			Mi	iddle Initial:	Last Nan	ne:		
Address:				City:		State:_	Zip	:
Phone: (one: ()Emergency Contact:Phone: ()		
Birth date:	//_	Age:	Sex:	M F Primary Care	Physician _			
The questions be		w us to dete	rmine if you	ı are eligible for a	vaccine toda	ay .If any question i	s unclear, p	lease ask a
			ALL VA	CCINES			YES	NO
2. Have you ev	sick today or liver fainted on ver had a react	felt dizzy afte	r receiving a					
 Do you have neurologic 	ve long-term	health proble	em with hea	ort disease, lung dis e, metabolic disease				
immune sys	stem, long ter			e of HIV/AIDS or ar uch as high-dose ste				
	-			vaccines? (Examples nerosal?	: eggs, B-bov	ine protein,		
Guillain Bar	re' syndrome	or other nervo	ous system pi			in disorder,		
			_	ing pregnant next m containing products				
,	-			vir) within the past 4				
•	more than 10		-					
12. If you are 65	5 older have y	ou had a pneu	ımonia shot?					
			LIVE VA	CCINES				
	rently on hom							
-	-			he past four weeks?				
	eceived a trans obulin in the p		od, blood pro	ducts or been given	a medication	called immune		
		•	e (including r	nyasthenia gravis), o	r thymectom	ny? (Yellow Fever)		
				ial medications? (O				
questions about the nfluenza vaccine ou understand and agre appropriate state an	contents of the tweigh the risks ee that this com id federal regula bsidiaries, office is vaccination. I	Vaccine Inform associated wit pany may be re story authoritie ers, employees, am 18 years or	nation Stateme h receiving the quired by appl s for purposes agents, repres older, under no	nt. I understand the be vaccine. I hereby consicable law to report ces such as reporting of ad entatives, contractors,	nefits and risk sent to have th tain informati verse events o successors and d and understa	accine(s) listed below. I s of the vaccine, and I be e vaccine administered to on without notice to me or immunization registried d assignees from any clai and this informed conser- try, if I have one.	elieve that ber to me by the c about my vac s. I further ag im or action a	efits of receiving the ompany pharmacist. cination to the ree to hold harmless rising out of or, in an
way incidental to thi communicate the inf By signing below, I c	ertify that I am	the patient or t	he patient's gu	ardian/personal repres	entative signir	ng on behalf of the patie	nt. I read, und	erstand and agree to
vay incidental to thi communicate the inf By signing below, I c	ertify that I am	the patient or t	he patient's gu	ardian/personal repres	entative signir	ng on behalf of the patie	nt. I read, und	erstand and agree to
vay incidental to thi communicate the inf By signing below, I co Ill the statements of	ertify that I am	the patient or t		e of Patient or Leg			nt. I read, und	erstand and agree to
vay incidental to thi communicate the inf By signing below, I co ill the statements of Print Name	ertify that I am n this form.	Vaccine	Signatur	e of Patient or Leg	al Guardian	Date	nt. I read, und	_
way incidental to thi communicate the inf By signing below, I co all the statements of Print Name	ertify that I am		 Signatur			Date Site of Injection		erstand and agree to
way incidental to thi communicate the in	ertify that I am n this form.	Vaccine	Signatur	e of Patient or Leg	al Guardian	Date		_
way incidental to thi communicate the inf By signing below, I co all the statements of Print Name	ertify that I am n this form.	Vaccine	Signatur	e of Patient or Leg	al Guardian	Date Site of Injection	'PLUA 'PLUA	_