Fetter Health Care
NETWORK

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2021 INFLUENZA VACCINE PATIENT QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

1. Do you have an allergy to eggs or Neomycin that causes dangerous reactions?

   Yes _____ No_____

2. Have you ever had lasting paralysis (loss of sensation, power, or motion in parts of the body) or been told that you have Guillain-Barre Syndrome?

   Yes _____ No_____

3. Are you or might you be pregnant?

   Yes _____ No_____

4. Do you have a fever, or are you presently ill?

   Yes _____ No_____

Consent Form

I have read the adverse reactions associated with the influenza and pneumococcal vaccines. A copy of the vaccine manufacturer's drug information sheet is available upon request. Furthermore, I also had an opportunity to ask questions about these immunizations. I believe the benefits outweigh the risks and I assume full responsibility for any reactions that may result. My medical record may be shared with my physician / insurance companies. I am requesting that the immunization be given to me or the person named above, for whom I am the legal guardian. I, for myself, my heirs, executors, and assigns hereby release Fetter Health Care Network from any and all claims arising out of, in connection with or in any way related parties shall not at any time or any extent whatsoever be liable, responsible, or in any way accountable for any loss, injury, death or damage to be suffered or sustained by any person at any time in connection with or as a result of this vaccine program.

Patient Signature: _____

Date: _____