



REAGAN MEDICAL CENTER, LLC

2878 Five Forks Trickum Rd., Lawrenceville, GA 30044 Tel: 678-344-8700
Hamilton Medical @ 3685 Braselton Hwy, Dacula, GA 30019 Tel: 678-546-9800
10160 Medlock Bridge Road, Johns Creek, GA 30097 Tel: 678-387-1600
All locations Fax: 678-344-8600 Reaganmedical.com

Flu Consent Form

Name: _____ DOB _____

Address: _____

City _____ State _____ Zip _____

Phone Number: _____ SS# _____

Emergency Contact name and phone #: _____

I hereby authorize the medical staff of Reagan Medical Center to administer an influenza vaccine to me. I attest to the following statements:

1. At the present time I am without fever and I am not experiencing any flu like or upper respiratory type symptoms.
2. I am not allergic to eggs or egg products.
3. I have not had an allergic reaction to the influenza vaccine in the past.
4. I do not have diseases that inhibit my immune system.
5. I am not taking drugs that suppress my immune system.
6. I am not pregnant.
7. I agree to wait 15 minutes after I receive my influenza vaccine.
8. I will be rechecked at this time for a possible allergic reaction.

I have thoroughly read and agree with all the statements listed above. I wish to waive my right to be examined by a physician prior to receiving the influenza vaccine. I release Reagan Medical Center, It's affiliates and/or agents of all liabilities that may arise by signing below.

Signature: _____ Date: _____

THIS AREA IS FOR OFFICE PERSONNEL ONLY

Temp: _____ Symptom free: Yes or No

Influenza lot # _____ Expiration Date: _____

Location of Injection: R deltoid _____ L deltoid _____

Time of Injection: _____ Reaction: Yes or No

Administered By: _____