NORVAR HEALTH SERVICES
1001 Connecticut Ave. NW
Suite 210
Washington, DC 20036
(202) 744-1360

INFLUENZA IMMUNIZATION CONSENT FORM

I hereby give my consent voluntarily and of my own free will to Norvar Health Services and its personnel to administer the seasonal influenza vaccine injection to me. I declare that I am older than 18 years of age and that:

- I am not allergic to chicken eggs
- I have never had a severe allergic reaction after getting any flu vaccine
- I do not have a bleeding disorder

I understand that if I have any condition contrary to the above, I could be at risk for medical complications from the vaccine and therefore, I should not receive the immunization.

I understand that while the risks associated with the influenza vaccine are rare, possible adverse reactions include, but are not limited to: 1) Nerve Paralysis, 2) Guillain-Barré Syndrome, 3) Encephalitis, and 4) Allergic reactions. I also understand that it is not possible to predict all possible side effects or complications associated with the influenza vaccine.

I understand that receipt of the influenza vaccine injection is voluntary and my consent is given in light of this knowledge. I, for myself, my heirs, my executors and my assigns, hereby release Norvar Health Services and its employees and agents from any and all claims, damages, losses, costs, expenses, actions of any nature whatsoever (including, without limitation, attorney's fees) arising from, in connection with or in any way, directly or indirectly, associated with receipt of the influenza vaccine.

I agree to wait in the immediate area for 5 minutes after receiving the vaccine.

□ I am over 65 years of age and I would like to receive the HIGH-DOSE flu vaccine.

□ I am over 65 years of age and I would like to receive the REGULAR-DOSE flu vaccine.

□ I am under 65 years of age.

_____ _____ _____
Signature Date Print Name

_____
Nurse's signature

Brand administered _____ Lot Number _____ □ Quadrivalent □ High-dose