

**Dear Parent/Guardian,
If your child is 10 years of age or older and you will not be accompanying them for their vaccination please fill out and sign this consent form.**

**Thank You,
Lois Poepsel**

**BEFIT HEALTH SERVICES, INC.
CONSENT TO VACCINE ADMINISTRATION**

Please answer the following questions & provide the information requested below:

- | | | |
|--|-----|----|
| *1. Have you ever had a reaction to the vaccine indicated? | YES | NO |
| *2. Are you allergic to eggs? | YES | NO |
| *3. Do you have a fever? | YES | NO |
| *4. Are you pregnant? | YES | NO |

I, _____, do hereby give my permission to the BeFit Health Services (BHS) staff to administer to me/my child the following vaccine(s): Influenza I have received & have read or have had explained to me the information for the vaccine indicated. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits & risks of the vaccine requested and ask that the vaccine be given to me or the person named below for whom I'm authorized to make this request. If I should become ill while receiving the vaccine(s), I give permission to the BHS staff to administer that treatment which they consider necessary for my well-being.

I understand that a copy of BHS Notice of Privacy Practices has been made available for my review and my questions have been answered to my satisfaction.

* _____			0.5cc IM
Print Name	Witness	Clinic Location	Site / Dose / Route
Date	Mfg./Lot#/Expir. Date	Nurse's Signature	
