



**WARHAWK
HEALTH SERVICES**

Vaccine Consent and Administration Record

Name: Terasu Harmony Koda DOB: 2/7/2008 Phone: 334-657-1525

Mailing Address: 7239 Greenfield Rd City: Mont. ST: AL Zip: 36117

Insurance Company: BCBS Subscriber name: David Koda DOB: 2/07/2008

Insurance Contract Number: _____ Group number: _____

Screening Questions:	Yes	No	Don't Know
1) Are you sick today? (cold, fever, acute illness)	☐	☒	☐
2) Do you have allergies to any foods, medications or latex? (For example: eggs, gentamycin gelatin, food, neomycin, thimerosal, or vaccinations) List <u>penicillin</u>	☒	☐	☐
3) Have you had any serious reactions from a vaccine?	☐	☒	☐
4) Have you been diagnosed with Guillain-Barre syndrome?	☐	☒	☐

Consent for Services: I have been provided with the Vaccine Information Sheet corresponding to the vaccine that I am receiving. I have read or have had explained the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I request that the vaccine be given to me or the person named above for whom I am authorized to make this request,

Signature <u>[Signature]</u>	Date <u>10/10/23</u>
Administration Date <u>10/10/23</u>	Route: IM <u>LD</u> or RD Volume: 0.5ml
Administrator <u>[Signature]</u>	VIS Date 08/06/2021
Manufacturer: GSK Fluarix® Quadrivalent Lot # G2ML4 Expires 06/30/2024	
Temp: <u>97.8</u>	

NDC 58160-909-41
Rx Only
Influenza
Vaccine
FLUARIX QUADRIVALENT
2023/2024 Formula

0.5 mL

Mfd. by
GlaxoSmithKline
Biologics

514456