



### Vaccine Consent and Administration Record

Name: TAREK ELBADAWY DOB: \_\_\_\_\_ Phone: (334) 320 8049

Mailing Address: 9184 Autumn Brook City Montg ST: Al Zip: 36117

Insurance Company: BCBS Subscriber name: \_\_\_\_\_ DOB: \_\_\_\_\_

Insurance Contract Number: \_\_\_\_\_ Group number: \_\_\_\_\_

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

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 [Signature] Date 08/23/2023

Administration Date 8/23/2023 Route: IM LD or RD Volume: 0.5ml

Administrator M. Bicknell, RN VIS Date 08/06/2021

Manufacturer: GSK Fluarix® Quadrivalent Lot # G2ML4 Expires 06/30/2024

Temp: 97.3

LOT: G2ML4  
EXP: 06/30/24

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

Mfd by  
GlaxoSmithKline  
Bioscience

0.5 mL

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