Total Wellness Corporate Health
7017 North Robinson
Oklahoma City, Oklahoma 73116

Consent for Immunization

Name: _____ Birthdate: ____/____/____
(Last) (First) (Middle Initial)

Address: _____
(Street) (City) (State) (ZIP Code)

Email: _____ Phone: _____ Male or Female _____
(Circle one)

Have you ever had a reaction to a vaccine? Yes ☐ No ☐ Are you allergic to eggs? Yes ☐ No ☐
Have you had a fever in the last 24 hours? Yes ☐ No ☐ Do you have Guillain-Barré syndrome? Yes ☐ No ☐
Females: Are you currently pregnant or breast feeding? Yes ☐ No ☐

Insurance Provider: _____ Policy/ID: _____ Group ID: _____

** Policy holder information is required if other than self. **

Policy Holder Name: _____ Birthdate: _____ Relationship: _____

	Lot	Expiration	Arm	Staff Initials
Flu:			Left Right	

Signature: _____ Date: ____/____/____

**By signing this document, I have verified that all information provided is correct, and that I have read the appropriate handout regarding the vaccine(s) I will be receiving today. I am aware of any risks or possible side effects that may occur.