

UT HARRIS COUNTY PSYCHIATRIC CENTER
CONSENT FOR TREATMENT
Influenza and/or Pneumonia Shots

PATIENT NAME: _____
 Date of Birth: _____ Age: _____



Addressograph

PRECAUTIONS & CONTRAINDICATIONS

Please Circle

Have you ever had a flu shot before? Yes No
Do you have a history of hypersensitivity to chicken eggs or egg protein? Yes No
Do you have any hypersensitivity to any component of the vaccine, including thimerosal? Yes No
Do you have a history of Guillain-Barre syndrome? Yes No
Do you currently have a fever, respiratory illness or any other type of infection? Yes No
Have you ever had a bad reaction to another vaccine? Yes No

Please list the adverse reaction. _____

Note – Pregnant women may not receive a pneumonia shot.

I have read/had explained to me the information about influenza and/or pneumonia as well as information regarding as influenza and/or pneumonia vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine/s and ask that the vaccine/s be given to me or to the person named above for whom I am authorized to make this request. I agree that UT Harris County Psychiatric Center shall have no responsibility or liability if I contract influenza, pneumonia, other respiratory diseases, or suffer any other adverse reaction following administration of the flu or pneumonia shot.

Signature of Responsible Person: _____

Date: _____

INFLUENZA VACCINE

INJECTION SITE: (CIRCLE ONE) LD RD

NURSE'S INITIALS: _____

MFG / LOT # _____

PNEUMONIA VACCINE

INJECTION SITE (CIRCLE ONE): LD RD

NURSE'S INITIALS: _____

MFG/LOT # _____