ALL AMERICAN FAMILY AND GERIATRIC CARE
Patient Consent and Release Form

PATIENT NAME (print): **DATE OF BIRTH:**

I hereby voluntarily consent to the following procedure(s)/treatment(s). I have been made aware of certain risks and/or consequences, which may be associated with or arise from having the treatment(s)/procedure(s) and do so of my own free will.

I have had an opportunity to discuss the benefits and risks of the procedure(s) indicated below with my healthcare provider and have had any and all questions answered to my satisfaction. I believe I understand the benefits and risks and request the procedure(s) indicated below for **ME** / **MY CHILD (circle one)**:

I release All American Family and Geriatric Care, and any of the associated physicians and practitioners/employees involved in this care from any liability.

CHECK ALL THAT APPLY:

☐	**IV Therapy** – With (spell out medication and dosage): _____ to be administered intravenously for – (# of days): _____. NDC# _____I have been educated in the signs and symptoms of possible IV site complications, possible allergic reactions, or side effects of the medication I am receiving and understand what measures to take should I experience any of them. See medical record for documentation of IV site, Mfg, Lot #, administering personnel.
☐	**Subcutaneous or Intramuscular Injection** of (spell out medication and dosage): _____. NDC#: _____ I have been educated in the signs and symptoms of possible injection site complications, possible allergic reactions, or side effects of the medication I am receiving and understand what measures to take should I experience any of them. Injection Site: Given By: Mfg: Lot #: Exp. Date:

I have read or had explained to me the information about the below indicated vaccine and have been educated in the signs and symptoms of possible injection site complications, possible allergic reactions, or side effects of the below indicated vaccine and understand what measures to take should I experience any of them:

☐ **Flu Vaccine**

- Has the person receiving the vaccine ever had a severe allergic (hypersensitivity) reaction to eggs, chickens, or chicken feathers? ☐ Yes ☐ No
- Does the person receiving the vaccine have a history of Guillain-Barre syndrome or a persistent neurological illness? ☐ Yes ☐ No
- Is the person receiving the vaccine pregnant? ☐ Yes ☐ No (if yes, LIAV contraindicated, LIV recommended)
- For children younger than 9 years, has the child received the influenza vaccine in the past? ☐ Yes ☐ No (If no, the child will need to receive 2 vaccinations [at least 1 month apart] for the best protection against flu)

☐ **Meningococcal** ☐ **Shingles Vaccine**

☐ **Pneumonia Vaccine** ☐ **Hemophilus Influenza**

☐ **Human Papilloma Virus Vaccine** ☐ **Typhoid**

☐ **Hepatitis A** ☐ **Hepatitis B**

☐ **Tetanus** ☐ **Other:**_____

Injection Site: Given By:
Mfg: Lot #:
Exp. Date: Temp: NDC#:

Patient/Guardian Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____