*The Center for Integrative Health*
*Dwana Bush, M. D.  Ayesha Shaikh M.D.*
*755 Mt Vernon Hwy NE  Suite 350*
*Atlanta, GA  30338*
***Phone 404-255-5774***

# Flu Vaccination Authorization Form

Patient's Name: _____ Date of Birth: _____

Mailing Address: _____

_____

Primary Contact Phone #:_____

I hereby voluntarily request and authorize The Center for Integrative Health to administer the influenza (flu) vaccine to me.

**I understand that I should not have the vaccine if I have any of the following**:

- Allergies to eggs
- A past history of Gullain-Barre Syndrome
- A past reaction to receiving the flu vaccine
- Am pregnant, have the possibility of being pregnant, or am breast feeding
- Have sensitivity to Gentamicim, Tobramycin or other Aminoclycocides
- Currently have a fever or febrile illness
- An active neurological disorder or seizures
- Sensitivity to Thimerosal

Please advise the nurse in advance of receiving the vaccine if you are taking blood thinners, asthma medication, radiation or chemotherapy, have an impaired immune system, or have an allergy to latex.

For any discomfort after the vaccination, you may take two Tylenol every four to six hours for two days.

Signature: _____ Date: _____

## For established patients of our practice:

I understand that as a courtesy you will bill my insurance company for this vaccine. If my insurance company does not cover this expense, I will pay personally for this service.

_____
**Signature**

****************************For Office Use Only***************************
**Influenza Vaccine**
**Administered by: _____**
**Dose: _____**
**Manufacturer: _____ Lot No. _____ Exp. Date: _____**
**Inj. Site: L Deltoid R Deltoid**