Total Wellness Corporate Health

7017 North Robinson
Oklahoma City, OK 73116

Patient Number _____

Consent for Immunization

First Name (Legal) | MI | Last Name

Date of Birth | Male or Female (circle one) | ( ) Phone Number

Home Address | City | State | Zip Code

Have you ever had a reaction to a vaccination? Yes ☐ No ☐
Have you had a fever in the last 24 hours? Yes ☐ No ☐
Females: Are you currently pregnant or breast feeding? Yes ☐ No ☐

Are you allergic to eggs? Yes ☐ No ☐
Do you have Guillain-Barre syndrome? Yes ☐ No ☐

Primary Insurance Provider	Member ID Number		Group/Policy Number
Policy Holder Name	**D.O.B.**	**Gender**	**Relationship**
		Male or Female (circle one)	

Secondary Insurance Provider	Member ID Number		Group/Policy Number
Policy Holder Name	**D.O.B.**	**Gender**	**Relationship**
		Male or Female (circle one)	

Signature: _____ Date: / /

*** By signing this document, I have verified that all information provided is correct, and 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.*

Please complete everything above the yellow line

	Lot	Expiration	Arm	Staff Initials
FLU			Left Right	
shingles	Lot	Expiration	Arm	Staff Initials
			Left Right	
B12:	Lot	Expiration	Arm	Staff Initials
			Left Right	
	Lot	Expiration	Arm	Staff Initials
			Left Right	
	Lot	Expiration	Arm	Staff Initials
			Left Right	