# Vitamin B Consent Form

First Name: Middle Initial:

Last Name:

Birthdate: Age: Sex(M/F)

**Please check *YES* or *NO* for each question, if you have any questions, please ask for assistance.**

| | YES | NO |
|---|---|---|
| 1. Are you allergic to aluminum, colbalt and vitamin B, preservatives, streptomycin or latex? | | |
| 2. Do you have a history of Leber's disease or active neurological disorder? | | |
| 3. Have you ever had a serious reaction after receiving any vaccination or vitamin B Shot? | | |
| 4. Do you have any type of infection, iron or folic acid deficiency, kidney or liver disease or receiving any medications or treatment that affects bone marrow? | | |
| 5. **For Women:** Are you pregnant or suspect you are pregnant? If so, please speak with the nurse before receiving the vitamin B shot. | | |

**CHECK WITH YOUR PHYSICIAN AND/OR YOUR HEALTHCARE PROVIDER BEFORE RECEIVING VITAMIN B IF YOU CHECKED *"YES"* ON ANY OF THE ABOVE QUESTIONS.**

**PARTICIPANTS WHO SHOULD NOT TAKE THE VITAMIN B SHOT**

- Persons with an allergy to aluminum, colbalt, and/or Vitamin B.
- Those with a history of a serious reaction to a previous VITAMIN shot.
- Anyone who has Leber's disease, an infection, Folic acid deficiency, receiving any treatment or medication that has an effect on bone marrow.
- Pregnant women during the first 3 months of pregnancy, absent current written approval from their doctor.
- Persons with impaired kidney and liver function.

**POSSIBLE SIDE EFFECTS FROM THE VACCINE:**

Most people have no side effects from vitamin B. Vitamin B shots are given by injection into a muscle of the upper arm. This may cause soreness for a day or two at the injection site and occasionally may also cause a fever or aches for one or two days. Rare side effects that can occur after vaccination include life-threatening allergic reactions and possibly Leber's Disease (optic nerve damage).

THE VITAMIN B SHOT SHOULD NOT BE ADMINISTERED TO PEOPLE WITH ALLERGIES TO ALUMINUM, COLBALT, AND/OR VITAMIN B, HAVE A HISTORY OF LEBER'S DISEASE, AND HAVE IMPARIED KIDNEY OR LIVER FUNCTION. HOWEVER, MINOR ILLNESSES WITH OR WITHOUT FEVER SHOULD NOT CONTRAINDICATE THE USE OF VITAMIN B SHOT, PARTICULARLY AMONG CHILDREN WITH MILD RESPIRATORY TRACT INFECTION OR ALLERGIC RHINITIS.

**WARNING: PLEASE CHECK WITH YOUR PHYSICIAN BEFORE TAKING THE VITAMIN B SHOT.**

**CONSENT FOR SERVICES, MEDICAL RECORDS & HIPPA PRIVACY INFORMATION**

I hereby acknowledge full and complete consent to and make request for a vitamin B shot. I am physically able to have this vaccine and have never had an adverse reaction to a vitamin B shot. I hereby request and authorize The Wellness Group, LLC's designated subcontractor who is an independent nurse/ healthcare staffing agency, not directly affiliated with The Wellness Group, LLC, to administer this vaccine to me or the person named above for whom I am the legal guardian. I hereby release The Wellness Group, LLC, its principals, directors, members, employees, affiliates, suppliers, providers, subcontractors, successors, agents, their respective insurance carriers, and the location sponsoring this clinic/program, its principals, directors, employees, affiliates, successors, or agents from any and all liability, injury or damage whatsoever arising from, or in any way connected with, this vitamin B Shot or the administration of same including, but not limited to, acts of negligence. I authorize my medical information herein to be shared with my physician/insurance. I have voluntarily requested this vaccine outside the course and scope of my employment. The Wellness Group, LLC will use and disclose your personal and health information to treat you, to receive payment for the care we provide, and for our other health care operations which generally include those activities we perform to improve quality care. We have prepared a detailed **NOTICE OF PRIVACY AND CONFIDENTIALITY PRACTICES** to help you better understand our policies in regards to your personal health information. I acknowledge that I have received a copy of the Notice of Privacy and Confidentiality Practices. I agree to remain in the general area for at least 15 minutes after receiving the vaccine. **Please provide a copy of this form to your physician and/or healthcare provider for your medical records.**

Signature of Recipient or Legal Guardian Signature Date of Service

**Vaccine Information (Nurse Use Only)**

| | | | |
|---|---|---|---|
| MFR | Lot # | Exp. Date | 1 mL<br>Dosage Amount |
| IM<br>Route | Left Deltoid | Right Deltoid | Admin. Date |
| Nurse Signature | | Company or Store Name where clinic is taking place | |