2017 Influenza Immunization Consent Form

Name: First ______________________ **Middle Initial** _____ **Last** ________________________________ ☐ **M** ☐ **F**

Address ____ **Phone** ___________________________

City ________________________________ **State** _____ **Zip Code** _________ **Date of Birth** ___________

Insurance Carrier:

❍ Medicare ❍ Aetna Medicare ❍ Anthem Medicare ❍ ConnectiCare Medicare

❍ Aetna ❍ Anthem ❍ ConnectiCare ❍ Cigna ❍ No Insurance

❍ Other Insurance __________________________ **Insurance ID #** ___________________________

Is the Insurance policy in your Name? If NO, please fill out the information below:

Name of person who carries the insurance ____

Their Date of Birth ________________ Your Relationship to Them _____________________

Their Insurance ID # _____________________________

Please answer the following questions:

❍ Yes ❍ No Are you allergic to eggs or thimerosal?
❍ Yes ❍ No Have you ever had a serious reaction to a flu shot?
❍ Yes ❍ No Are you sick with a fever or are you taking an antibiotic for an infection?
❍ Yes ❍ No Have you ever had Guillain-Barré Syndrome?
❍ Yes ❍ No Have you ever had a flu shot?

I have read, or have had explained to me, the information sheet about influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the flu vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or Medicare HMO claim, or for other insurance purposes**. I agree that if my insurance company does not pay for the vaccine or if a co-pay or deductible applies, I will be responsible for payment.**

I acknowledge receipt of the Notice of Privacy Practices: I have had the opportunity to ask questions regarding my rights relating to the use and disclosure of my Protected Health Information (PHI).

Signature of Recipient (or Guardian): ____________________________________ **Date:** _____________

For clinic use only ☐ **HHCAH** ☐ **HCFX**

Vaccine Type: ❍ __________________ ❍ **FluBlok** **Lot #** ________________ **Exp. Date** ___________
(Please enter appropriate vaccine type & lot number – needed for billing)

Injection Site: ❍ **Right Arm** ❍ **Left Arm** **For Pediatric Clients Dosage:** ____________________

Clinic site: ❍ **Client Home** ***or*** ❍ **Name of Clinic** ____
(Please check one location and/or write name of clinic – needed for billing)

Nurse's signature ___________________________________ **Date Admin.** _______________________
(Signature of Nurse and date vaccine administered – needed for billing)