

2020 Influenza Immunization Consent Form

Please Print Legibly

Name: First _____ Middle Initial _____ Last _____ M F

Address _____ Phone _____

City _____ State _____ Zip Code _____ Date of Birth _____

Primary Insurance Company:

Insurance ID# _____

Do not write in names – only use checkbox options below

- Medicare Aetna Medicare Anthem/BCBS Medicare ConnectiCare Medicare
 Aetna Anthem/BCBS ConnectiCare Cigna

Who carries the health insurance? Self Other Person (a parent, spouse, etc.)

Self-Pay: Flucelvax – \$45 Flublok – \$80 **Please Note:** If your insurance is not listed above, Self-Pay rates will apply

Check # _____ Check Date _____ Check/Cash Amount \$ _____

Please answer the following questions:

- Yes No **Have you ever had a flu shot?**
 Yes No Are you allergic to eggs or Thimerosal?
 Yes No Have you ever had a serious reaction to a flu shot?
 Yes No Have you ever had Guillain-Barré Syndrome?
 Yes No Are you experiencing fever, muscle aches, loss of sense of smell or taste, congestion, nausea, vomiting or diarrhea or are you taking an antibiotic?

Temperature _____

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 Nurse use only

(Please select Vaccine Name and enter Lot Number and Expiration Date)

Injection Site: Right Arm **Vaccine:** Flucelvax Lot # _____ Exp. Date _____
 Left Arm FluBlok Lot # _____ Exp. Date _____

Nurse's signature _____ Date Admin. _____
 (Signature of Nurse and date vaccine administered)

Clinic Location/Company Name _____

(Please clearly print name of clinic or company as listed on Flu Schedule)