



2016 Influenza Immunization Consent Form

Name: First _____ 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

Other _____ Insurance ID # _____

Subscriber's Name _____ Subscriber's ID# _____

Subscriber's Date of Birth _____ Patient's Relationship to Subscriber _____

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?
- 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: Fluvirin FluBlok Lot # _____ Exp. Date _____
(Please check 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)