INFLUENZA VACCINATION CONSENT

Last Name: _____First Name: _____ Middle Initial: _____

Address:_____City/State:_____Zip Code:_____

Phone Number:_____E-mail (optional)_____

Date of Birth: _____ Age:_____ Gender: □ Male □ Female □ Other

Ethnicity: ❑American Indian/Alaska Native ❑Asian ❑Black/African American ❑Native Hawaiian/Pacific Islander ❑White

Race: ❑Hispanic/Latino ❑Not Hispanic/Latino

		Please Circle	
1.	Are you 18 years of age or older?	Yes	No
2.	Have you ever received the flu vaccine?	Yes	No
3.	If yes, did you have a serious reaction? Explain:_____	Yes	No
4.	Are you allergic to eggs or egg products? If no, skip to question 5.	Yes	No
	If yes, have you received the egg-free vaccine?	Yes	No
	Did you have any reaction to the egg-free vaccine?	Yes	No
5.	Have you had a fever, respiratory infection, nausea, vomiting or diarrhea within the last 24 hours?	Yes	No
6.	Have you ever been paralyzed by Guillain-Barré Syndrome?	Yes	No
7.	Have you received any vaccine in the past 30 days?	Yes	No
8.	Are you allergic to or do you have a known hypersensitivity to neomycin sulfate or polymyxin B?	Yes	No
9.	Are you on anticoagulant therapy?	Yes	No
10.	Females Only: Are you pregnant?	Yes	No

I have received and reviewed a copy of the Influenza Vaccine Statement. I have had a chance to ask questions and these have been answered to my satisfaction. I understand the benefits and risks of the influenza vaccine. I consent to receive the vaccine. I may experience mild reactions including soreness at the injection site, aches, and mild fever. If I begin to have wheezing or breathing problems, hives, or severe rash I am to immediately report to the nearest emergency room for treatment of a possible severe allergic reaction and follow up with my primary care physician.

_____

Signature of person to receive vaccine or person authorized to make request Date

For Office Use Only

Clinic Site: _____ AMITA Health Location: ❑HFMC ❑MMC ❑RMC ❑SJHE ❑SMEMC ❑SMK

Vaccine Manufacturer Name
Lot# / Expiration Date

Injection Site:
□ Right Deltoid □ Left Deltoid

Vaccine Information Statement (VIS) received
❑Inactivated Influenza Vaccine 8.06.2021 version _____ Initials

_____ _____

Signature and title of health professional administering the vaccine Date

INFLUENZA VACCINATION BILLING FORM

Last Name: _____First Name: _____ Middle Initial: _____

Address:_____City/State:_____Zip Code:_____

Phone Number:_____ Email (optional):_____

Date of Birth:_____ Age:_____ Gender: □ Male □ Female □ Other

Ethnicity: ❑American Indian/Alaska Native ❑Asian ❑Black/African American ❑Native Hawaiian/Pacific Islander ❑White

Race: ❑Hispanic/Latino ❑Not Hispanic/Latino

For Office Use Only

For Self-Pay Only

Total Amount $_____ □ Cash □ Check #_____

□ Client is paying for the following person(s):_____

For Waiver Only

□ Client is unable to pay.

I am unable to afford the cost of a flu vaccination at this time and am requesting that it be given to me at no charge.

_____ _____

Client signature Registration staff or RN signature

For Medicare Patients Only

Medicare Part B number exactly as it appears on the Medicare Card

My signature below indicates my approval for AMITA Health to bill Medicare for the cost of today's flu vaccine and administration. I understand that Medicare Part B provides coverage for one flu vaccination and administration per year.

_____ _____

Signature of person to receive vaccine or person authorized to make request Date