



2018 Influenza Immunization Consent Form MDA36 Locations

Name: First _____ Middle Initial _____ Last _____ M F

Address _____ Phone _____

City _____ State _____ Zip Code _____ Date of Birth _____

Insurance Company: _____ Insurance ID# _____

- Medicare Aetna Medicare Anthem/BCBS Medicare ConnectiCare Medicare
- Aetna Anthem/BCBS ConnectiCare Cigna
- Harvard Pilgrim United HealthCare Medicaid
- Other Insurance _____ No Insurance

Who carries the health insurance? (self, parent, spouse, etc.)

Their Name _____ Their Birth Date _____

Their Insurance ID # _____ Your Relationship to Them _____

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 Are you sick with a fever or are you taking an antibiotic for an infection?
- Yes No Have you ever had Guillain-Barré Syndrome?

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

Vaccine: Fluarix Flucelvax FluBlok Lot # _____ Exp. Date _____
(Please select Vaccine Name and enter Lot Number and Expiration Date)

Injection Site: Right Arm Left Arm

Clinic Location/Company Name _____
(Please clearly write name of clinic or company as listed on Flu Schedule)

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