

# INFLUENZA VACCINE CONSENT/ADMINISTRATION RECORD



<b>Name:</b>		<b>Birth Date:</b>	<b>Sex:</b> M F
<b>Address:</b>		<b>City:</b>	
<b>State:</b>	<b>Zip:</b>	<b>Phone:</b>	
<b>PLEASE ANSWER THE FOLLOWING QUESTIONS. If you answer "YES" to any question(s), additional information may be needed before receiving the vaccination.</b>		<b>YES</b>	<b>NO</b>
Is the person being vaccinated sick today?			
Is the person being vaccinated allergic to eggs or to a component of the vaccine?			
Is the person being vaccinated allergic to Thimerosal (a mercury derivative found in contact lens solution and Merthiolate)?			
Does the person being vaccinated have a latex allergy?			
Has the person being vaccinated ever had a serious reaction after receiving an influenza vaccination?			

**PLACE A CHECK OR INITIAL BESIDE EACH OF THE FOLLOWING STATEMENTS:**

- I have received a copy of the influenza vaccine information sheet.
- To the best of my knowledge, I understand the benefits and/or risks of the influenza vaccine.
- I have had a chance to ask questions about the vaccine that were answered to my satisfaction.
- I request to receive the influenza vaccine, or request the vaccine be given to the above-named individual for whom I am authorized by law to make said request.
- I have received and/or have had explained to me the Notice of Privacy Practices Summary, which explains the policies concerning my personal health information.

I authorize \_\_\_\_\_ to release to the below-named insurance company any medical or other information required to process a claim for benefits. I understand that \_\_\_\_\_ will accept assignment of my claim and my signature below authorizes said intermediary to pay benefits on my behalf, directly to \_\_\_\_\_. I understand that any information so released will be treated as confidential by \_\_\_\_\_, in accordance with the \_\_\_\_\_'s HIPAA policies.

*Signature of person receiving vaccine or person authorized to make the request (parent/guardian):*

X \_\_\_\_\_ **Date:** \_\_\_\_\_

**CHECK THE BOX BY YOUR PRIMARY INSURANCE COVERAGE. WRITE DOWN INSURANCE NUMBERS AND HAVE INSURANCE CARD OUT. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES INCURRED IF MEDICARE/PRIMARY INSURANCE COVERAGE DOES NOT PAY.**

<input type="checkbox"/>	Medicare	<input type="checkbox"/>	Medigold
<input type="checkbox"/>	Medicaid (Billing Number)	<input type="checkbox"/>	Other

**TO BE COMPLETED BY HEALTHCARE PERSONNEL:**

<b>Healthcare Provider:</b>	<b>Injection Site:</b> LD RD Intranasal	<b>Vaccine Manufacturer</b> _____ <b>Lot #</b> _____ <b>Expiration Date:</b> _____
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