INFLUENZA VACCINATION RELEASE AND CONSENT

Date: ______________ First Name: ______________ Last Name: ______________

Age: ______________ Birthdate: ______________ Sex: ☐Male ☐Female

Social Security Number: ______________ Parent/Guardian: ______________

Address: ______________________________ City: ______________

Zip: __________ State: ______ Home Phone: ______________ Cell Phone: ______________

☐ **Injection ($25.00)** **unless any of the following options apply to you:**

☐I am Medicare Part B eligible. Medicare Number: ______________

☐I am on Medicaid. Medicaid Number: ______________

☐I have private insurance that covers flu vaccine (*office co-pay may apply*).

Insurance Name: ______________ ID Number: ______________

☐I am on Hawk-I. Hawk-I Number: ______________

☐I am 18 years of age or younger and do not have insurance coverage for my flu vaccine.

Please answer the following questions by circling the appropriate responses:

1. Are you allergic to chicken, eggs, chicken feathers, or mercury? ☐Yes ☐No
2. Have you ever had a reaction to a flu shot? ☐Yes ☐No
   If yes, please explain: ______________
3. Have you ever received the influenza vaccine before? ☐Yes ☐No
4. Are you feeling sick today? ☐Yes ☐No

I have read the information and have had the chance to ask questions. I understand the benefits and risks of the influenza vaccine and ask that the vaccine be given to me, or the person named above. I accept responsibility for seeking medical attention for any problems with this vaccination. I authorize billing of this vaccination to Medicare, Medicaid, Hawk-I, or private insurance, if applicable.

Patient/Parent Signature: ______________________ Date: ______________

**************************************FOR OFFICE USE ONLY***

Site: **Rt / Lt** and **D / VL**

Dose: **0.25 cc IM / 0.5 cc IM**

VFC

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Clinician Signature: ______________________

Is 2nd dose needed? Yes No When?______________

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PRIVATE

Entered in SUCCESS: _____/_____/_____ Initials: ______