ADIRONDACK HEALTH & WELLNESS

INFLUENZA IMMUNIZATION CONSENT FORM

PATIENT INFORMATION ***All information is required***

Legal First Name			**Last Name**		
Date of Birth	**Age**	**Sex**	**Mother's Maiden Name** (required for all persons under 19)		
Address		**City**	**State**	**Zip**	**Phone**
Health Insurance Company			**Email Address**		
Insurance ID #	**Group #**		**Insurance Policy Holder Name & Date of Birth:**		

Please note if your insurance is denied for any reason, it is the responsibility of the recipient to pay the fee

Please complete the questions below for yourself or the person receiving the vaccination

Have you received any other vaccine in the last 4 weeks?		☐ No	☐ Yes
Are you currently on a high dose of steroids?		☐ No	☐ Yes
Have you ever had a reaction to the flu vaccine?		☐ No	☐ Yes
Are you allergic to eggs or egg products?		☐ No	☐ Yes
Do you have a history of Guillain-Barre Syndrome? (Illness associated with the swine flu in 1976)		☐ No	☐ Yes
Are you allergic to thimerosal (a mercury-based preservative)**?**		☐ No	☐ Yes
Are you allergic to latex?		☐ No	☐ Yes
Do you feel ill today, or do you have a fever?		☐ No	☐ Yes
Are you pregnant?	☐ N/A	☐ No	☐ Yes
Have you taken antiviral medication for the flu within the last 48 hours?		☐ No	☐ Yes
Are you a child or adolescent receiving long term aspirin therapy?		☐ No	☐ Yes

PLEASE SIGN BELOW

Influenza Consent

I have read, or had explained to me, the Vaccination Information Statement about ***influenza*** vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the ***influenza*** 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 other insurance claim or for other public health purposes. I have received a copy of the Patient Bill of Rights.

I accept financial responsibility if my insurance is not accepted or denied.

X_____

Signature of Recipient (Parent or Guardian) **Date**

TO BE COMPLETED BY NURSE:

Administration Date:

Administration Site: ☐ Left Arm ☐ Right Arm ☐ Left Thigh ☐ Right Thigh

Dosage: ☐ 0.5 ml

Manufacturer: _____

Lot Number: _____

Expiration Date:

Nurse Signature:

Next Immunization Due: ☐ Next Year ☐ In 4 weeks ☐ Other_____

PATIENT COPY

Patient Name:	**Administration Date:**
Address:	**Administration Site:** ☐ Left Arm ☐ Right Arm ☐ Left Thigh ☐ Right Thigh
	Dosage: ☐ 0.5 ml
	Manufacturer: _____ **Lot Number:** _____
	Date:
Patient Signature:	**Nurse Signature:**
Date:	**Next Immunization Due:** ☐ Next Year ☐ In 4 weeks ☐ Other_____