2017-2018 SEASONAL
INFLUENZA CONSENT FORM

(Statement of Understanding, Permission, and Agreement)

Last Name: First Name: MI:

Social Security #: Date of Birth: Race:

Address:

Sex: Male Female Phone Number:

Insurance Name: Policy/Group #:

Medicare #: Medicaid #:

(Please complete all sections of this form) (Copy front and back of Insurance Card)

STATEMENT OF UNDERSTANDING: I have read and I understand the information provided to me about receiving vaccines for influenza, and I have had the opportunity to ask questions. I understand that being allergic to eggs may be a reason for not receiving the influenza vaccine. I affirm to the best of my knowledge that the following questions have been answered truthfully:

	Circle Yes or No	
1. Are you allergic to EGGS?	Yes	No
2. Have you had a serious allergic reaction to influenza vaccine?	Yes	No
3. Do you have a history of Guillain-Barre' Syndrome?	Yes	No
4. Do you have asthma?	Yes	No
5. Do you have a latex allergy?	Yes	No

STATEMENT OF PERMISSION AND ASSIGNMENT: I voluntarily give my permission to receive the influenza vaccine. I understand that payment for this service may be made in accordance with the provisions of Title XVIII of the Social Security Act (Medicare), and /or Title XIX of Social Security Act (Medicaid), and /or private insurance or third party payer. I hereby authorize the provider of service to release information necessary for the processing of any claim for payment made on behalf, and I authorize payment to the provider for such claim. **I understand that I am responsible for any costs incurred that are not covered by a third-party payer.**

Signature (Patient or Guardian) Date

Influenza Vaccine **For Provider Use Only:** Mfr: **Injection Site:** (Circle One) Lot #: **Right Deltoid** Expires: **Left Deltoid**

Administered By:_____ Date:_____