# INFLUENZA VACCINATION ASSESSMENT & CONSENT FORM

Billed
AR
MCIR

Yes No

Have you ever had a reaction to a flu shot?

Are you allergic to eggs, egg products, latex, or thimersol (found in some eye cosmetics, ear, nose & eye meds)?

Are you sick with a fever greater than 100 degrees Fahrenheit?

Do you have a history of Guillain-Barre' Syndrome (a neurological disorder) or any other neurological disorder?

Have you ever had a severe allergic reaction? (food, medicine, flu shots, other), i.e. hives, breathing difficulty, shock, requiring emergency medical treatment or within 48 hours of a previous vaccine? If yes, specify _____

Have you had another immunization in the last 14 days? If yest, please list _____

Are you currently undergoing Chemotherapy? Last tx? _____ Next tx date? _____

## QUESTIONS

If you have any questions about the Influenza Disease or the Influenza Vaccination, please ask the nurse for clarification now or call your doctor before requesting the vaccine. If you have any questions or concerns following the vaccination, please call the MC VNA at 248-967-1440. If you experience any adverse effects from the Influenza Vaccination, please contact your physician and notify the MC VNA (also notify your employer if you received your vaccination at work).

## CONSENT AND RELEASE FOR INFLUENZA VACCINE

- I have read the Vaccination Information Sheet regarding the Influenza Vaccine. I have had an opportunity to ask questions, and my questions have been answered to my satisfaction. I understand the benefits and risks of the Influenza Vaccination as described. I request that the vaccine be given to me. I understand the vaccination is being provided by MC VNA. **I expressly release MC VNA from any liability resulting from the Influenza Vaccine.**

- I agree to remain under observation for at least 15 minutes. Should I leave before that period lapses, I expressly release MC VNA from any liability resulting from any adverse reaction to the vaccine which may occur during that period and thereafter. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense. I understand side effects may include, but are not limited to: soreness at the injection site, fever, fatigue and headache. There is some risk for Guillain-Barre Syndrome. Severe reactions may include anaphylaxis and death.
- In the event a MC VNA employee is exposed to my blood or other body fluids, I agree to have my blood tested for HIV and Hepatitis and have the results released to MC VNA/exposed person, but not to anyone else unless required/authorized by law.
- I acknowledge that I have received written information on MC VNA's "Notice of Privacy Practices" prior to the provision of service, and I have had the opportunity to have my questions answered.

- Unless cash\check are indicated below, I wish to have MC VNA bill my insurance for the cost of my shot. MC VNA agrees to accept provider payment.
- I acknowledge that I am responsible to reimburse MC VNA for either charges not covered by my insurance or applied to my deductible.

## CLIENT INFORMATION

Legal Name *(as it appears on card)* | M F | Birthdate | Age | Weight (if < 110 lbs)

Street Address / Apt. No. | City | State | ZIP | Telephone

Client has one of the following insurance plans with VACCINE COVERAGE? ☐ BCN BCBS *(except TEA prefix or Anthem)* McLaren

☐ COPS Trust (SOM) Medicare Part B PHP Priority Health HAP *(except CIGNA)*

☐ Cash - Amt: _____ Check - Number\Amount: _____ ☐ Clinic Paid

Insurance Contract / Enrollee / Subscriber / Member ID | Responsible Party or Cardholder Information | Responsible Party Birthdate

Signature of Client/Guardian | Date | Email Address

I have received a flu shot in the past? Yes No

***TO BE COMPLETED BY CLINIC STAFF***

GSK Dose 6 Months & Older
0.5 cc Quadrivalent A & B
Right Deltoid IM
Left Deltoid IM
Right Thigh IM
Left Thigh IM

High Dose 65 Years & Older
0.5 cc HD Trivalent A & B
Right Deltoid IM
Left Deltoid IM

Sanofi Dose 6 Months to 35 Months
0.25 cc Quadrivalent A & B
Right Thigh IM
Left Thigh IM

Lot #/ Exp Date | Nurse Signature | Date

Clinic Name/Date: _____