

McLaren Print System Order

Order No: 48047 Reprint Previous Order No: 5506
 Order Date: 2019-08-27
 User: Rebecca Stevens
 Phone: 517-896-1519

Ship Location: WILLIAMSTON FAMILY MEDICINE
 1288 WEST GRAND RIVER
 WILLIAMSTON, MI 48895

Forms

Quantity: 100
 Paragon Dept No: 67000
 Dept Name: WILLIAMSTON FAMILY MEDICINE
 Company Number: 810

Order Total Price: 23.40

Item Number: MM-474
 Item Description: Influenza Consent Form
 Revision Date: 8/2019
 Print: 1 sided black and white
 Paper: 2 Part (White, Yellow)
 Size: 8.5 x 11
 Fold:
 Finish:
 Drill: None
 Misc Info: This form must be ordered with DCH-0457

McLaren MEDICAL GROUP

INFLUENZA CONSENT & ADMINISTRATION FORM

Last Name _____ First Name _____ Sex: Male Female
 Address _____ Date of Birth _____
 City _____ State _____ Zip _____
 Telephone: (____) _____ Primary Care Provider (PCP) _____

Not all individuals requesting the influenza vaccine can be safely immunized. Please complete the following questions to evaluate any contraindications to the influenza vaccine.

1. Do you have any serious, life-threatening allergies? Yes No
 If yes, describe the allergies: _____
2. Have you ever had a severe reaction to a previous influenza vaccine or any of its components? Yes No
 If yes, describe the reaction: _____
3. Do you have a fever or acute illness? Yes No
4. Do you have a past history of Guillain-Barre Syndrome? Yes No
5. Do you have a history of asthma or wheezing? (for intranasal administration only) Yes No

Be well any medication, there are risks and possible side effects/reactions. Side effects/reactions of influenza vaccine are generally mild, usually occur soon after vaccination and can persist for 1-2 days. In rare cases, side effects/reactions of influenza vaccine may include anaphylaxis and even death. If you think you are having a severe reaction or other emergency, SEEK MEDICAL CARE IMMEDIATELY.

I have reviewed and received the influenza vaccine information statement and have had the opportunity to ask questions. I have been advised to remain under observation for at least 15 minutes following vaccination. I understand the benefits and the risks of the influenza vaccine as described. I hereby agree to release and hold McLaren Medical Group, its employees, agents and representatives, harmless from further responsibility with regard to my receiving the vaccine. I request the influenza vaccine to be given to me or to the person named for whom I am authorized to sign.

Signature of Patient or Authorized Representative (include relationship) _____ Date _____
If Under 18, Signature of Parent or Legal Guardian Required (include relationship)

 Clinic staff: For any YES response and an active patient, review with the provider. Otherwise, refer patient back to their PCP.
 I have reviewed and authorize vaccine administration. Provider Signature _____ Date _____ Time _____
McLaren Medical Group was unable to administer your influenza vaccine today due to a contraindication. Please take a copy of this form to your Primary Care Provider.

FOR MEDICARE PATIENTS ONLY

I request that this provider be paid authorized Medicare benefits on my behalf for any services furnished to me. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine those benefits for related services. I understand that I am responsible for the charges if my Medicare coverage is not appropriate. Medicare Number _____
 Patient Signature _____ Payment to Patient Payment to Provider

Site of injection: Right Deltoid Left Deltoid Right Anterolateral Thigh Left Anterolateral Thigh Intranasal

Lot Number _____ Manufacturer _____ Expiration Date _____

Administered by _____ Date _____ Time _____

INFLUENZA CONSENT FORM - Original - Order Copy - Patient MM-474, Rev. 8/2019