

McLaren Print System Order

Order No: 55535 Reprint Previous Order No: 5506
Order Date: 2020-07-22
User: Joann Provost
Phone: 810-667-7335

Ship Location: McLaren Lapeer CMC
1254 N. Main Street
Lapeer, MI 48446

Forms

Quantity: 500
Paragon Dept No: 50504
Dept Name: McLarenLapeer Community Medical Center
Company Number: 810

Order Total Price: 117.00

Item Number: MM-474
Item Description: Influenza Consent Form
Revision Date: 6/2020
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



INFLUENZA CONSENT & ADMINISTRATION FORM

Form fields for Patient Name, Sex, Date of Birth, Address, City, State, Zip, Telephone, and Primary Care Provider (PCP).

Note all individuals requesting the influenza vaccine can be safely vaccinated. Please complete the following questions to evaluate any contraindications to the influenza vaccine.

- 1. Do you have any serious, life-threatening allergies?
2. Have you ever had a serious reaction to a previous influenza vaccine or any of its components?
3. Do you have a fever or active illness?
4. Do you have a past history of Guillain-Barre Syndrome?
5. Do you have a history of asthma or wheezing? (for intranasal administration only)

As with 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 last 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, STOP, SEEK HELP, CALL 911/EMERGENCY.

I have received and reviewed the Influenza Vaccine Information Statement (VIS) (2019) 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 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) and Date. Includes a checkbox for clinic staff to sign if they administered the vaccine.

FOR MEDICARE PATIENTS ONLY. I request that this provider be paid authorized Medicare benefits... Patient Signature and checkboxes for Payment to Patient or Payment to Provider.

Site of Injection (Right/Left Arm/Thigh) and fields for Lot Number, Manufacturer, Expiration Date, and Administration Date/Time.