

McLaren Print System Order

Order No: 56683 Reprint Previous Order No: 5506
Order Date: 2020-09-08
User: Katie Jacobs
Phone: 9893457000

Ship Location: Main Street Family Practice-JILL UHOUSE
117 S Burgess Street
West Branch, MI 48661

Forms

Quantity: 500
Paragon Dept No: 69990
Dept Name: McLaren
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, 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 severe, life-threatening allergies?
2. Have you ever had a severe 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 911/911/911.

I have received and reviewed the Influenza Vaccine Information Statement (IS) (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 consent 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 box for PCP signature and date.

FOR MEDICARE PATIENTS ONLY. I request that this provider be paid authorized Medicare benefits... Patient/Signature, Medicare Number, Payment to Patient, Payment to Provider.

Sex of Injection, Lot Number, Manufacturer, Expiration Date, Administered by, Date, Time.