

McLaren Print System Order

Order No: 56719 Reprint Previous Order No: 5506
Order Date: 2020-09-10
User: Tracy Spencer
Phone: 586-493-3732

Ship Location: McLaren Macomb Pediatrics /Attn Tracy
16700 21 Mile Rd Suite 104
Macomb, MI 48044

Forms

Quantity: 500
Paragon Dept No: 72550
Dept Name: McLaren Macomb Pediatrics
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 IMMEDIATELY.

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) Date
Check staff: For any YES responses 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/Defect Left/Defect Right/Asymmetrical Thigh Left/Asymmetrical Thigh Unintended
Lot Number Manufacturer Expiration Date
Administered by Date Time