

McLaren Print System Order

Order No: 56815 Reprint Previous Order No: 5506
Order Date: 2020-09-15
User: Kimberly Gunsell
Phone: 989-316-4272

Ship Location: McLaren Bay Family Medicine
3720 Katalin Ct Suite 201
Bay City, MI 48706

Forms

Quantity: 100
Paragon Dept No: 69000
Dept Name:
Company Number: 810

Order Total Price: 23.40

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 (ISVIS) (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 the risks of the influenza vaccine as described. I hereby agree to receive 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)

Check staff, For any YES responses and an active patient, review with the provider. Otherwise, return 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 these 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, Unknown

Lot Number, Manufacturer, Expiration Date

Administered by, Date, Time