

McLaren Print System Order

Order No: 56886 Reprint Previous Order No: 5506
Order Date: 2020-09-17
User: colleen taraskavage
Phone: 810-658-6503

Ship Location: MMG Davison Community Medical Center
10090 E. Lippincott Blvd
Davison, Michigan 48423

Forms

Quantity: 500
Paragon Dept No: 50002
Dept Name: MMG Davison CMC
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. If yes, describe the allergies.
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 (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 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 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 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 Anterior Thigh Left Anterior Thigh Other
Lot Number Manufacturer Expiration Date
Administered by Date Time