McLaren Medical Group

INFLUENZA CONSENT FORM

Last Name: _____ First Name :_____ Sex: ❑ Male ❑ Female

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____ Primary Care Provider (PCP): _____

Not all individuals requesting the flu vaccine can safely be immunized against influenza. Please complete the following questions to evaluate any contraindication:

For any YES response: If active patient at this site, review with the provider. Otherwise, refer the patient back to their PCP.

❑ I have reviewed and authorize vaccine administration. Provider Signature_____ Date_____Time____

1.	Have you ever had a severe reaction to a previous influenza vaccine? Describe: _____	❑ Yes	❑ No
2.	Are you allergic to eggs, chicken feathers, chicken or chicken dander?	❑ Yes	❑ No
3.	Are you allergic to Thimerosal (a mercury derivative found in contact lens solution and Merthiolate)?	❑ Yes	❑ No
4.	Are you allergic to Latex?	❑ Yes	❑ No
5.	Do you have a fever or active illness?	❑ Yes	❑ No
6.	Are you pregnant?	❑ Yes	❑ No
7.	Do you have a past history of Guillain-Barre Syndrome?	❑ Yes	❑ No
8.	Have you received another type of vaccine in the past fourteen (14) days?	❑ Yes	❑ No
9.	Are you under the age of eighteen (18)?	❑ Yes	❑ No
10.	Are you currently receiving blood thinners such as coumadin, aspirin or heparin?	❑ Yes	❑ No

Influenza vaccine is composed of dead influenza viruses and will not give you the flu. It is given by injection. As with any medication, there are risks and possible side effects/reactions. Side effects of influenza vaccine are generally mild in adults and occur within 6-12 hours after vaccination and can persist for one or two days. These reactions consist of soreness of the injection site, fever, chills, muscular aches and, in rare cases, even death. **If you should have a reaction, CONTACT YOUR PRIMARY CARE PROVIDER.**

Having received influenza vaccine information (dated 8/19/14) and informed consent, 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 injections.

I have read the above information and have had the opportunity to ask questions. I understand the benefits and risks of the influenza vaccine as described. I request the flu vaccine to be given to me or to the person named for whom I am authorized to sign.

_____ _____

Signature: Patient or Authorized Representative (Relationship) **Date**

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

❑ We were unable to administer your influenza vaccine today due to a contraindication. Please take a copy of this form to your primary care provider.

Site of injection: ❑ Right Deltoid ❑ Left Deltoid ❑ Right Anterolateral Thigh ❑ Left Anterolateral Thigh

Lot #: _____ Manufacturer: _____ Expiration Date: _____

Given by:_____ Date: _____ Time: _____