

## McLaren Print System Order

Order No: 6536  
 Order Date: 2014-10-16  
 User: Danielle Cahoon  
 Phone: 810-688-3093

Ship Location: McLaren Family Care Center/Danielle Cahoon  
 4482 Huron Street  
 North Branch, MI 48461

### Forms

Quantity: 100  
 Paragon Dept No: 65250  
 Dept Name: McLaren Family Care Center-North Branch  
 Company Number: 810

Order Total Price: 11.70

Item Number: MM-474  
 Item Description: Influenza Consent Form  
 Revision Date:  
 Print: 1 sided black and white  
 Paper: 2 Part (White, Yellow)  
 Size: 8.5 x 11  
 Fold:  
 Finish:  
 Drill: None  
 Misc Info: Vaccine Information Statements are ordered separately.

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 responding to the flu vaccine can safely be immunized against influenza. Please complete the following questions to evaluate any contraindications.

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?  Yes  No  
 Describe \_\_\_\_\_
2. Are you allergic to eggs, chicken feathers, chicken or chicken tender?  Yes  No
3. Are you allergic to Thimerosal (a mercury derivative found in certain lens solution and Merthiolate)?  Yes  No
4. Are you allergic to latex?  Yes  No
5. Do you have a fever or swollen throat?  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 or moderate and occur within 12 hours after vaccination and subside for one or two days. These reactions consist of soreness at the injection site, fever, chills, muscle aches and/or sore throat. If you should have a reaction, CONTACT YOUR PRIMARY CARE PROVIDER.

Having received influenza vaccine information (dated 8/18/10) 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 vaccine.

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 \_\_\_\_\_

**INFLUENZA CONSENT FORM**  
ORIGINAL - Center COUNTY - Patient