McLaren
MEDICAL GROUP

INFLUENZA CONSENT & ADMINISTRATION 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 influenza vaccine can be safely immunized. Please complete the following questions to evaluate any contraindication to the influenza vaccine.

1. **Do you have any severe, life-threatening allergies?** ❑**Yes** ❑**No**
   If yes, describe the allergies: _____
2. **Have you ever had a severe reaction to a previous influenza vaccine or any of its components?** ❑**Yes** ❑**No**
   If yes, describe the reaction: _____
3. **Do you have a fever or active illness?** ❑**Yes** ❑**No**
4. **Do you have a past history of Guillain-Barre Syndrome?** ❑**Yes** ❑**No**
5. **Do you have a history of asthma or wheezing? (for intranasal administration only)** ❑**Yes** ❑**No**

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 can persist 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, SEEK MEDICAL CARE IMMEDIATELY.

I have received and reviewed the Influenza Vaccine Information Statement (8/6/2021) 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 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 response 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 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 Deltoid ❑ Left Deltoid ❑ Right Anterolateral Thigh ❑ Left Anterolateral Thigh ❑ Intranasal

Lot Number: _____ Manufacturer: _____ Expiration Date: _____

Administered by: _____ Date: _____ Time: _____