

McLaren Print System Order

Order No: 72322 Reprint Previous Order No: 5506
 Order Date: 2022-09-13
 User: TINA PLAUTZ
 Phone: 12486742259

Ship Location: McLaren Oakland Waterford Medical Associates
 5210 Highland Rd Suite 201
 Waterford, MI 48327

Forms

Quantity: 500
 Paragon Dept No: 73000
 Dept Name: Waterford Medical Associates
 Company Number: 810

Order Total Price: 117.00

Item Number: MM-474
 Item Description: Influenza Consent Form
 Revision Date: 8/2021
 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

McLaren
MEDICAL GROUP

INFLUENZA CONSENT & ADMINISTRATION FORM

Last Name _____ First Name _____ Sex Male Female

Address _____
 City _____ State _____ Zip _____

Telephone _____ Primary Care Provider (PCP) _____

Not all individuals receiving the influenza vaccine can be safely vaccinated. Please complete the following questions to evaluate any contraindications to the influenza vaccine.

- Do you have any current or developing allergies? Yes No
 If yes, describe the allergy: _____
- Have you ever had a severe reaction to a previous influenza vaccine or any of its components? Yes No
 If yes, describe the reaction: _____
- Do you have a fever or active illness? Yes No
- Do you have a past history of Guillain-Barre Syndrome? Yes No
- Do you have a history of seizures or bleeding? (for intranasal administration only) Yes No

As with all medications, 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 empty/empty nose and nose bleed. 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 (ISVIS) and have had the opportunity to ask questions. I have been advised to receive each administration for at least 17 months 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 _____
(Under 18, Signature of Parent or Legal Guardian Required - include relationship)

Check 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 will continue 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

Size of Injection: High Dose Low Dose High Assisted Low Assisted High Low

Lot Number _____ Manufacturer _____ Expiration Date _____

Administered by _____ Date _____ Time _____

INFLUENZA CONSENT FORM - Original - Cassa Casey - Patient MM-474 Rev. 8/2021