

McLaren Print System Order

Order No: 79331 Reprint Previous Order No: 5506
Order Date: 2023-09-12
User: Danielle Cahoon
Phone: 810-346-2757

Ship Location: McLaren Brown City Healthcare Center /Danielle Cahoon
7115 Cade Road
Brown City, MI 48416

Forms

Quantity: 500
Paragon Dept No: 50676
Dept Name: McLaren Brown City Healthcare Center
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 VACCINE & ADMINISTRATION FORM
Last Name, First Name, Sex, Date of Birth, 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.
1. Do you have any known life-threatening allergies?
2. Have you ever had a severe reaction to a previous influenza vaccine or any of its components?
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 seizures or bleeding? (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 can persist for 1-2 days. In rare cases, side effects/reactions of influenza vaccine may include empty/empty 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 (VIS/7021) 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
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
Sex of recipient, Lot Number, Manufacturer, Expiration Date, Administered by, Date, Time
INFLUENZA CONSENT FORM - Original - Cassin Casey - Patient MM-474 Rev. 8/2021