

McLaren Print System Order

Order No: 79605 Reprint Previous Order No: 5506
 Order Date: 2023-09-25
 User: Mary Bitzer
 Phone: 18103421711

Ship Location: McLaren Fenton CMC Primary Care / ATTN Mary Bitzer
 2420 Owen Rd, Suite A
 Fenton, MI 48430

Forms

Quantity: 500
 Paragon Dept No: 50013
 Dept Name: McLaren Fenton CMC Primary Care
 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.

| | | |
|--|------------------------------|-----------------------------|
| 1. Do you have any known life-threatening allergies? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, describe the allergen: _____ | | |
| 2. Have you ever had a severe reaction to a previous influenza vaccine or any of its components? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, describe the reaction: _____ | | |
| 3. Do you have a fever or active illness? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Do you have a past history of Guillain-Barre Syndrome? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Do you have a history of seizures or rabies? (for intranasal administration only) | <input type="checkbox"/> Yes | <input type="checkbox"/> 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 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 (VIS/7021) 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 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

Site of Injection: Right Deloid Left Deloid Right Anterolateral Thigh Left Anterolateral Thigh Intranasal

Lot Number _____ Manufacturer _____ Expiration Date _____

Administered by _____ Date _____ Time _____

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