

McLaren Print System Order

Order No: 88447
 Order Date: 2024-09-25
 User: Sarah Sturock
 Phone: 5179753720

Ship Location: Grand Ledge Family Practice
 935 Charlevoix Dr., Suite 200
 Grand Ledge, MI 48837

Form
 Quantity: 100
 Paragon Dept No: 51062
 Dept Name: McLaren Medical Group
 Company Number:

Order Total Price: 23.40

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
 Poster:
 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 _____ Date of Birth _____
 City _____ State _____ Zip _____
 Telephone _____ Primary Care Provider (PCP) _____

Not all individuals requesting 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 serious, life-threatening allergies? Yes No
 If yes, describe the allergy: _____

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

In all my medical history, there are no 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 myalgia 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/2021) and have had the opportunity to ask questions. I have been advised to receive another alternative for at least 13 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 _____
 If Under 18, Signature of Parent or Legal Guardian Required (include relationship) _____

Class staff: For any YES response and an active patient, review with the provider. Otherwise, refer patient back to their PCP. Please recommend and authorize vaccine administration. Provider Signature: _____ Date: _____

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 the provider be paid/authorized Medicare benefits on my behalf for any services furnished to me. I authorize _____ of medical or other information about me to release to the Centers for Medicare and Medicaid Services (CMS) and _____ of information needed to determine those 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: _____

INFLUENZA CONSENT FORM - Original - Green Copy - Patient 986-076 Rev. 8/2021

Spec. Info: