



## Flu Shot Consent Form

NAME - PRINT EXACTLY AS WRITTEN ON INSURANCE CARD		PHONE NUMBER	
ADDRESS		CITY	STATE      ZIP
DATE OF BIRTH	AGE	SEX male or female	
PRIMARY INSURANCE <input type="checkbox"/> AETNA <input type="checkbox"/> AETNA MEDICARE <input type="checkbox"/> ANTHEM BC/BS MEDICARE <input type="checkbox"/> BC/BS (ANTHEM) <input type="checkbox"/> CONNECTICARE <input type="checkbox"/> CONNECTICARE MEDICARE <input type="checkbox"/> HEALTH NET MEDICARE <input type="checkbox"/> MEDICARE PART B <input type="checkbox"/> OXFORD <input type="checkbox"/> WELLCARE MEDICARE <input type="checkbox"/> CASH/CHECK \$ _____			
INSURANCE ID	NAME OF INSURED IF DIFFERENT THAN ABOVE	RELATIONSHIP TO INSURED	

If you answer yes to any of the following questions, please advise the nurse - "Yes" answers may disqualify you from receiving the flu shot.

Y N

- Is this your first flu vaccination? \*If yes, you must stay for 10-15 minutes observation after shot.
- Have you ever had a serious reaction to a flu shot?
- Are you sick with a fever today?
- Do you have a severe (life threatening) allergy to eggs?
- Are you allergic to thimersol (a preservative used in some contact lens solutions)?
- Have you ever had Guillian-Barre syndrome (a severe neurological disorder)?

I have read, or had explained to me, the 7/26/11 Vaccine Information Sheet (VIS) regarding inactivated influenza vaccine and Bethel VNA's privacy policy. I have had an opportunity to ask questions which were answered to my satisfaction and I understand the benefits and risks of the vaccination as described. I request that the influenza vaccination be given to me (or the person above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim. I understand that Bethel VNA will submit my claim to my insurance carrier as a courtesy. I understand I am responsible for any copay or deductible and if for any reason my claim is denied I understand that I will be billed for the entire amount of the service.

SIGNATURE	DATE
IF APPLICABLE: PRINT NAME OF PARENT OR GUARDIAN SIGNING ABOVE FOR CHILDREN UNDER 18	

**DO NOT SIGN OR DATE UNTIL DAY OF CLINIC  
BRING YOUR MEDICAL INSURANCE CARD**

### BELOW FOR CLINIC USE ONLY

- VIS Flu 7/26/11 Inactivated Influenza
- 0.5 cc IM LT Deltoid    or     0.5 cc IM RT Deltoid    or     0.25 cc IM LT Thigh    or     0.25 cc IM RT Thigh
- Fluvirin/Novartis PD 90656 or Q2037 lot #110401 exp 4/12
- Fluarix/GSK PD 90656 or Q2039 lot AFUA634BA exp exp 6/30/12
- Fluzone/Sanofi PD 90656 or Q2038 lot #UH464AA exp 6/30/12
- MDV Fluzone/Sanofi over 3 years 90658 or Q2038 lot #UH456AA exp 6/30/12
- MDV Fluzone/Sanofi *under 3 years* 90657 lot #UH456AA exp 6/30/12

NURSE SIGNATURE	IF UNDER AGE 8, IS THIS FIRST DOSE?
	<input type="checkbox"/> YES, counseled regarding second dose <input type="checkbox"/> NO