



Influenza Vaccine Consent Form (6 months and older)

1. Information about the person getting vaccinated. Please print clearly.

Last Name	First Name	Middle Initial	Date of Birth	Age
Street Address				
			Phone Number	

Place a checkmark about the person getting vaccinated:

Race: <input type="checkbox"/> American Indian/Alsk. Native <input type="checkbox"/> Hawaiian/Pac. Islander <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Other	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Other	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other
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2. Insurance Information (please fill out completely or attach a copy of insurance card).

Primary Insurance Name	Member/Insured ID#	Group ID# (if available)
Relationship to Subscriber/Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		Subscriber Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Subscriber/Insured Last Name	Subscriber/Insured First Name	Subscriber/Insured Date of Birth
Check Here if No Insurance <input type="checkbox"/>		

3. Authorization and Consent.

Consent for Use of Protected Health Information & Claims Agreement: I hereby consent to and acknowledge the receipt of a Notice of Privacy Practices regarding the use and disclosure of any personal health information for the purpose of health care operations, along with the assignment of all payment from the insurer listed above to VaxCare associated with the services contemplated herein. Vaccine authorization: my signature on this form indicates that I have requested that the vaccine indicated below be administered to me by a VaxCare station or VaxCare representative. I relieve VaxCare, the VaxCare partner, the administering nurse and personnel of any liability for any reactions that should occur. I unconditionally and irrevocably waive any right to a trial by jury, to the maximum extent allowed by law, for any claim or action arising out or related to this service, and that any such claim or action shall be determined solely on an individual basis through arbitration in accordance with Capital Commercial Rules of the American Arbitration Association. Neither I nor VaxCare shall be entitled to join or consolidate claims in arbitration by or against other individuals or entities or arbitrate any claims as a representative member of a class or in a private attorney general capacity. In the case of occupational exposure, VaxCare has permission for blood testing for patient and employee safety alike. I have read or had explained to me the information from the Vaccine Information Statement and understand the risks (including adverse events) and benefits of the vaccine. I understand I will be responsible for payment for the below vaccine, these services are not free, and that nonpayment by the insurance company or patient will result in collections for the amount due. Additionally, I understand that if I am I self-pay or no-pay patient receiving services, that all funds should be paid at the time of the service and not to VaxCare. If consenting for another, I have the legal authority, based on my relationship to the individual indicated above, to consent to this vaccine administration.

Signature of patient, or parent/legal guardian	Date
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4. Please answer the following questions by circling YES or NO

1.	Is the person to be vaccinated sick today?	Yes	No
2.	Does the person to be vaccinated have an allergy to mercury, thimerosal or chicken eggs?	Yes	No
3.	Has the person to be vaccinated ever had a serious reaction to an influenza vaccine in the past?	Yes	No
4.	Has the person to be vaccinated ever had Guillain-Barré Syndrome?	Yes	No

.....For Office Use Only.....

PATIENT DOES NOT COMPLETE THIS SECTION

Vaccination Details (Adhere label or print clearly.)		
<input type="checkbox"/> Sanofi Pasteur <input type="checkbox"/> AstraZeneca <input type="checkbox"/> GSK	Lot#: Exp. Date:	Site: <input type="checkbox"/> LD <input type="checkbox"/> RD <input type="checkbox"/> LT <input type="checkbox"/> RT Route: <input type="checkbox"/> IM <input type="checkbox"/> Intranasal
Administrator Signature:	Date:	<small>Nurse/Administrator: I hereby attest by my signature that the patient (or guardian of patient) in question has been provided access to and explained the Vaccine Information Statement and appropriate immunization schedules and has given verbal and written consent for vaccination.</small>