Influenza Vaccination Assessment, Release & Consent Form

(Please print)

Name____Date______________

____________ (Individual receiving vaccination)

Address___________________________________Telephone # (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

City________________________________State________Zip_______________Birth date ____/____ /______

County of Residence________________________________Gender M_______ F______

Physician_______________________________________Address______________________ ____________

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DO YOU HAVE MEDICARE, PART B? _____Yes _____No
IF "YES" FILL IN YOUR NUMBER AND LETTER IN THE SPACES BELOW:

____ ____ ____ - ____ ____ - ____ ____ ____ ____ - ______
(Medicare Number) (Letter)

Have you ever had a severe (anaphylactic) reaction to a flu shot? Are you allergic to eggs or egg products, thimerosal-containing products (eye contact lens solution) or mercury containing products? Do you currently have an illness where you are running a temperature?
_____YES _____NO

I have read the information or have had the information explained to me. I have had a chance to ask questions and these have been answered to my satisfaction. I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me, or to the person named above for whom I am authorized to make this request. I accept responsibility for seeking medical attention for any problems with this vaccination. I authorize billing of this vaccination to Medicare, Part B.

Signature:____________________________________

FOR NURSES' USE ONLY:

SITE: RD/LD LOT #:______________________EXPIRATION DATE_____________________________
MANUFACTURER:_________________________ADMINISTERED BY:____________________________