

INFLUENZA IMMUNIZATION CONSENT FORM

Name (please print) _____	Date of Birth _____
Street Address _____	City/State _____ Zip Code _____
Sex _____	Phone _____

Please show proof of all medical cards!

MEDICARE Part B		HealthNet		ConnectiCare/ Medicare Advantage	SELF PAY
_____ Medicare Number	OR	<input type="checkbox"/> HealthNet SmartChoice Medicare Advantage Plan <input type="checkbox"/> HealthNet Healthy options <input type="checkbox"/> HealthNet _____ HealthNet Number	OR	<input type="checkbox"/> ConnectiCare <input type="checkbox"/> ConnectiCare Medicare Advantage _____ ConnectiCare Number	<input type="checkbox"/> Cash <input type="checkbox"/> Check # <input type="checkbox"/> Credit C. V / MC

Do you have allergies to eggs or other substances?	No	Yes
Have you ever had a serious reaction to a flu shot?	No	Yes
Have you ever had a neurological disease or Guillian-Barre Syndrome?	No	Yes
Are you sick with a fever?	No	Yes
Are you pregnant?	No	Yes
Is this your first flu shot?	No	Yes
Are you the age of 9 or under?	No	Yes

I have read, or had explained to me, the information sheet about **influenza (flu)** vaccine. I have had a chance 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 **flu** vaccination be given to me (*or the person named 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 insurance claim or for other public health purposes. **In the event that my insurance does not cover the cost of my vaccine, I agree to make payment.**

Signature of recipient (or parent or guardian) _____
Date

Injection Site: <input type="checkbox"/> Left Arm <input type="checkbox"/> Right Arm
Manufacture & Lot Number: _____ MD/Nurse Signature: _____ Date _____