

Ascension Borgess Hospital

Flu Immunization Consent

Ages 9 years and older

Please Print

| | | | |
|-----------|------------|--------|--------------|
| Last Name | First Name | Middle | Phone Number |
|-----------|------------|--------|--------------|

| | | | |
|----------------|------|-------|----------|
| Street Address | City | State | Zip Code |
|----------------|------|-------|----------|

| | | |
|---|-----|---|
| Birthdate ____-__-____ Month Day Year | Age | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female |
|---|-----|---|

| | |
|--|-----------------------------|
| Name of Insurance (ex: Medicare, BCBS, United Healthcare, Priority Health, etc.) | |
| Member ID Number | Group Number (if available) |
| Provider Network (if available) | Policy/Contract Number |

| | | |
|---|---|---|
| If insurance is not in patient's name, complete the following information | | |
| Insured's Name | Insured's Birthdate ____-__-____ Month Day Year | Relationship to Insured <input type="checkbox"/> Spouse <input type="checkbox"/> Child |

Please turn page over

| | | | |
|--|-----------------------|--|--|
| Staff Use Only | | | |
| Non-Insurance Payment | Amount Paid: \$ _____ | <input type="checkbox"/> Cash | <input type="checkbox"/> Check # _____ <input type="checkbox"/> Bill Patient |
| Billing/payment information verified by _____ (initials) | | Clinic No. _____ | |
| <input type="checkbox"/> COVID-19 health screen questions answered | | <input type="checkbox"/> Temperature checked | |

CONSENT FORMS



*CONSENT *

Ascension Borgess Hospital

Flu Immunization Consent

Ages 9 years and older

Patient Name _____

Please circle the correct answer to the right

| | | |
|--|----|-----|
| 1. Have you ever had a flu shot? | No | Yes |
| 2. Have you ever had a life-threatening reaction to a flu shot? | No | Yes |
| 3. Are you running a temperature of 101 ⁰ F or over? | No | Yes |
| 4. Are you severely allergic to eggs, egg products, chicken or chicken dander? | No | Yes |
| 5. Do you have a known allergy to contact lens solution or thimerosal (a mercury derivative)? | No | Yes |
| 6. Have you ever been paralyzed by Guillain Barre Syndrome? | No | Yes |
| 7. Females only - Are you or could you be pregnant? If <u>yes</u> , has your physician recommended that you receive a flu shot? No Yes | No | Yes |
| 8. Have you ever received a pneumonia vaccine? <input type="checkbox"/> No <input type="checkbox"/> Yes If <u>Yes</u> , When? _____ (approx date) | | |

- I have read and received a copy of the Inactivated Influenza Vaccine Information Statement prior to my vaccination.
- I understand the risks and benefits involved. I have had a chance to ask questions and you answered them to my satisfaction. I want you to give the vaccine to me.
- I agree to stay in the general area for fifteen (15) minutes after receiving my vaccination. This is to watch for any reaction that may occur right away. We can't ensure that immediate reactions will not occur. I understand that if I experience any unusual or severe side effects, it will be my responsibility to seek emergency care or follow up with my personal physician at my expense.
- The Ascension Borgess Notice of Privacy Practices gives you information about how we use and disclose medical information about you. By signing this form, you are acknowledging that a copy was made available to you.
- Per Michigan Law, I am aware that Ascension Borgess may test my blood for HIV (AIDS virus), Hepatitis or other infectious diseases if a healthcare worker is exposed to my blood or body fluids during this vaccination process.
- I agree to reimburse Ascension Borgess if my medical insurance plan rejects payment.

Patient Signature
If patient is under 18 years of age or physically unable, the person authorized to make this request for patient listed above.

Relationship to person receiving vaccine if patient not signing.

 Date

 Time

| | | | |
|--|---|--|-------|
| Staff Use Only | Administered by _____ | _____ | _____ |
| | Nurse Signature / Title | Date | Time |
| <input type="checkbox"/> Sanofi Fluzone High Dose (65 yrs and up) 0.7 ml | <input type="checkbox"/> Seqirus Afluria 0.5 ml | Injection Site: Deltoid | |
| <input type="checkbox"/> GSK Flulaval 0.5 ml | <input type="checkbox"/> GSK Fluarix 0.5 ml | <input type="checkbox"/> Left <input type="checkbox"/> Right | |
| Lot Code: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G <input type="checkbox"/> H <input type="checkbox"/> I <input type="checkbox"/> J | | | |