NEN/NEHHS Flu Consent and Information Sheet

*Information about the person to receive vaccine (please print): *Required Fields*			
Name (Last, First, MI)*	Date of Birth* / /	Age*	Sex* Male Female
Street Address*			

City*	State*	Zip*	Phone*

Insurance Information: Include the whole member ID number and any letters that are a part of that number		
Name of Insurance Company*	Member ID Number*	Group Number if available
Medicare Number	Is Medicare Primary?	Is Subscriber Retired?

If Person getting vaccinated is not the subscriber, please complete the following:		
Subscriber's Name (Last, First, MI)*	Date of Birth* / /	Sex: Male Female
Subscriber's Street Address* (If different from address above)		

City*	State*	Zip*	Phone*

Patient Relationship to Subscriber: (Check)* Spouse Child Other

Please check your answer on the right side of the page

1. Is this the first flu shot you have ever had (in your life)? ………………………………………… No Yes
2. Are you sick today or are you running a temperature of 101.5° F or over?.............................. No Yes
3. Are you allergic to eggs, latex or Thimerosal?.. No Yes
4. Have you ever been diagnosed with Guillain-Barré Syndrome?.. No Yes
5. Do you take Coumadin or Warfarin?... No Yes
6. Have you ever had an allergic reaction or problem after a vaccination?.................................. No Yes
7. Have you had a flu shot in the last three years?.. No Yes

PATIENT CONSENT I have read the adverse reactions associated with the Influenza vaccine. A copy of the vaccine manufacturer's drug information sheet is available on request. I have also had an opportunity to ask questions about this immunization. I believe that the benefits outweigh the risks and I assume full responsibility for any reactions that may result. I waive and release any and all claims I, or anyone claiming by or through me, now have or may hereafter acquire against NEN/NEHHS and the clinic site sponsor and their respective directors, officers, employees, and agents for any and all damages or injuries if I, or the person named below for whom I am authorized to make this request, contract Influenza, other respiratory diseases, or suffer any other adverse reactions following administration of this flu shot. **In the event of an anaphylactic reaction, I agree to have 1. Epinephrine 1:1000 strength (0.5 ml, maximum) intramuscular injection, repeated every 10-20 minutes until symptoms subside, up to a maximum number of 3 times 2. Administer diphenhydramine Dose Oral, 25 and 50 mg capsule or tab. Both of these treatments are in accordance with our signed standing order for emergency treatment.** I understand that NEN/NEHHS can only bill certain insurances and that if I have an insurance NEN/NEHHS cannot bill, I am required to make payment to NEN/NEHHS at the time that services are provided unless other arrangements have been made. I have received a copy of the current Vaccine Information Statement created by the CDC.

I have read the above and give permission for my insurance company to be billed.

X ______________________________ Date: ______________

(Signature of patient or legal guardian)

For Clinic/Office Use Only:

Date of Service	Vax Type*					State Supplied	Preserv Free	Injection Route	Injection Site		Date on VIS
	IIV4					No	No	IM	___ R arm ___ L arm		08/07/2015

* IIV4 is inactivated influenza vaccine quadrilvalent **The VIS form was provided prior to the clinic date and at the time of the clinic.**

Signature of Vaccine Administrator: ______________________________ Date: ____________

Provider Name: **NEN/NEHHS** MDPH Provider PIN # 23443

Provider Address: **594 Marrett Rd, Suite 11, Lexington, MA 02421 781 862-5600 781 674-8600**

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