2011-2012 SEASONAL
INFLUENZA CONSENT FORM
(Statement of Understanding, Permission, and Agreement)

Last Name________________________________**First Name** ________________________ **MI**_____

_______________________ ____________ ____
Social Security Number **Date of Birth** **Race** **Sex: Male** _____ **Female**____

Address:__________________________________ Telephone #______________________
____

Medicare Number ___________________________ or **Insurance Name**_________________________
Medicaid Number ___________________________ Policy Number ___________________________
Address ___________________________
____
(Copy Front & Back of Insurance Card)

STATEMENT OF UNDERSTANDING: I have read and I understand the information provided to me about receiving vaccines for influenza, and I have had the opportunity to ask questions. I understand that being allergic to eggs may be a reason for not receiving the influenza vaccine. I affirm to the best of my knowledge that the following questions have been answered truthfully

	Circle Yes or No	
1. Are you allergic to eggs?	**Yes**	**No**
2. Have you had a serious allergic reaction Influenza vaccine?	**Yes**	**No**
3. Do you have history of Guillain-Barre' Syndrome?	**Yes**	**No**
4. Do you have asthma?	**Yes**	**No**
5. Do you have a latex allergy?	**Yes**	**No**

STATEMENT OF PERMISSION AND ASSIGNMENT: I voluntarily give my permission to receive the influenza vaccine. I understand that payment for this service may be made in accordance with the provisions of Title XVIII of the Social Security Act. (Medicare), and/or Title XIX of Social Security Act (Medicaid): and / or private insurance or third-party payer. I hereby authorize the provider of service to release information necessary for the processing of any claim for payment made on behalf, and I authorize payment to the provider for such claim. **I understand that I am responsible for any costs incurred that are not covered by a third-party payer.**

____ ______________________________
Signature (Patient or Guardian) **Date**__________________________

For Provider Use Only: **Influenza Vaccine Mfg.** **Lot #** **Expires:**
Injection Site:_____Right _____Left Deltoid
Administered by:__________________________
Date:_____________________________________