Influenza Vaccine Consent Form
(6 months and older)

1. Information about the person getting vaccinated. Please print clearly.

Last Name	First Name	Middle Initial	Date of Birth	Age

Street Address			

City	State	ZIP Code	Phone Number

Place a checkmark about the person getting vaccinated:

Race:		Gender:	Ethnicity:
☐ American Indian/Alsk. Native	☐ Hawaiian/Pac. Islnd.	☐ Female	☐ Hispanic
☐ Asian	☐ White	☐ Male	☐ Non-Hispanic
☐ Black/African American	☐ Other	☐ Other	☐ Other

2. Insurance Information (please fill out completely or attach a copy of insurance card).

Primary Insurance Name	Member/Insured ID#	Group ID# (if available)	
Relationship to Subscriber/Insured: ☐ Self ☐ Spouse ☐ Dependent			
Subscriber/Insured Last Name	**Subscriber/Insured First Name**	**Subscriber/Insured Date of Birth**	**Subscriber Gender** ☐ Male ☐ Female
Check Here If No Insurance ☐			

3. Authorization and Consent.

Consent for Use of Protected Health Information & Claims Agreement: I hereby consent to and acknowledge the receipt of a Notice of Privacy Practices regarding the use and disclosure of any personal health information for the purpose of health care operations, along with the assignment of all payment from the insurer listed above to VaxCare associated with the services contemplated herein. Vaccine authorization: my signature on this form indicates that I have requested that the vaccine indicated below be administered to me by a VaxCare station or VaxCare representative. I relive VaxCare, the VaxCare partner, the administering nurse and personnel of any liability for any reactions that should occur. I unconditionally and irrevocably waive any right to a trial by jury, to the maximum extent allowed by law, for any claim or action arising out or related to this service, and that any such claim or action shall be determined solely on an individual basis through arbitration in accordance with Capital Commercial Rules of the American Arbitration Association. Neither I nor VaxCare shall be entitled to join or consolidate claims in arbitration by or against other individuals or entities, or arbitrate any claims as a representative member of a class or in a private attorney general capacity. In the case of occupational exposure, VaxCare has permission for blood testing for patient and employee safety alike. I have read or had explained to me the information from the Vaccine Information Statement and understand the risks (including adverse events) and benefits of the vaccine. I understand I will be responsible for payment for the below vaccine, these services are not free, and that nonpayment by the insurance company or patient will result in collections for the amount due. Additionally, I understand that if I am I self-pay or no-pay patient receiving services, that all funds should be paid at the time of the service and not to VaxCare. If consenting for another, I have the legal authority, based on my relationship to the individual indicated above, to consent to this vaccine administration.

Signature of patient, or parent/legal guardian of a minor.		Date	

4. Please complete medical questions on the back of the form. ⟶ ⟶ ⟶

……For Office Use Only……

Vaccination Details (Adhere label or print clearly.)

☐ Sanofi Pasteur ☐ AstraZeneca ☐ GSK	Lot#: Exp. Date:	Site: ☐ LD ☐ RD ☐ LT ☐ RT Route: ☐ IM ☐ Intranasal
Administrator Signature:	Date:	Nurse/Administrator: I hereby attest by my signature that the patient (or guardian of patient) in question has been provided access to and explained the Vaccine Information Statement and appropriate immunization schedules, and has given verbal and written consent for vaccination.

Please answer the following questions by circling yes or no:

1.	Is the person to be vaccinated sick today?	Yes	No
2.	Does the person to be vaccinated have an allergy to mercury, thimerosal or chicken eggs?	Yes	No
3.	Has the person to be vaccinated ever had a serious reaction to an influenza vaccine in the past?	Yes	No
4.	Has the person to be vaccinated ever had Guillain-Barré Syndrome?	Yes	No

FOR PATIENTS RECEIVING FLUMIST (NASAL) VACCINE ONLY
Please complete additional questions.

5.	Is the person to be vaccinated younger than 2 years or older than 49 years?	Yes	No
6.	Has the person to be vaccinated had a diagnosis of asthma or reactive airway disease, or had wheezing in the past 12 months, or used medicines (such as inhalers) to prevent or treat wheezing in the past 12 months?	Yes	No
7.	Does the person to be vaccinated have a weakened immune system from any cause? **If yes, please describe**:	Yes	No
8.	Has the person to be vaccinated ever had a health problem with heart, lung, kidney, liver, metabolic (for example, diabetes), blood or neurological disease (for example, seizure disorder), or is currently receiving aspirin therapy? **If yes, please describe**:	Yes	No
9.	Has the person to be vaccinated received any vaccines in the past 4 weeks? **If yes, please list vaccines and dates:**	Yes	No
10.	Does the person to be vaccinated have close contact with anyone who has a severely weakened immune system? **If yes, please describe**:	Yes	No
11.	Has the person to be vaccinated received influenza antiviral medication in the last 48 hours?	Yes	No
12.	Is the person to be vaccinated pregnant or is there a chance she could become pregnant during the next month?	Yes	No