

Insurance Claim Form Consent Influenza Immunization

GetAFluShot.com
A Professional Health Care, LLC Company,
Established 1989 Community Immunization
Provider since 1991

Insurance Plan:	Regence Blue Cross	Providence Health Plan	Moda	Premera	Lifewise	Kaiser	Aetna
	Humana	Medicare	Pacific Source	Uniform Medical Plan	OR Medicaid	United Health Care	UMR
	Medicare Advantage	First Choice Health (Group # Req'd) _____			Other _____		
Primary Insurance ID _____							
Secondary Insurance ID _____							

Last Name _____

First Name _____

Your Street Address where you receive your insurance paperwork

City _____ **State** _____

Telephone (000-000-0000) () - _____ **Date of Birth(Month/Day/Year)** / / **Zip Code** _____

Male **Female** **Not Identified**

Email Address _____

Have you ever had a flu vaccination before?	Yes	No	Unsure	Are you allergic to a component of the vaccine?	Yes	No
Have you ever had a severe reaction to a flu shot?	Yes	No		Are you pregnant?	Yes	No
Do you have a history of Guillain-Barre Syndrome?	Yes	No				
Are you feeling sick today?	Yes	No				

I have read about possible adverse reactions to the vaccine and the **Vaccine Information Sheet**, and additional copies have been made available to me. I have had the chance to ask questions, and all have been answered to my satisfaction. I request that the vaccine be given to me or the person I am authorized to represent, and I accept the benefits and risks. I release GetaFluShot (GAFS), its affiliates, and related parties from any claims related to this immunization. I agree to pay for the vaccine and its administration if I do not have active or accepted insurance, and I consent to being contacted if more information is needed to process my consent or reimbursement.

Signature of responsible person	Relationship to Insured	Date Signed
X _____	Self Spouse Child	- -

Clinic Name _____ Date of Vaccination: _____ VIS 1/31/2025 Mfg/Lot #: _____ Expiration Date: _____ Nurse's Initials: _____ Site of Injection: L R Deltoid	NURSE NOTES
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