

Clerk Initials: _____

Verified by: _____

McLaren Visiting Nurse & Hospice
 Bay Flint/Lapeer Lansing Sterling Heights

INFLUENZA VACCINATION CONSENT

PLEASE PRINT (Legal Name)

First Name: _____ MI: _____ Last Name: _____

Home Address: _____

City: _____ County: _____ State: _____ Zip Code: _____

Phone Number: () _____ Age: _____ Date of Birth: _____ Male / Female

Children / adolescents under 99 lbs: Weight: _____

YES NO MEDICAL HISTORY

- Have you ever had a problem with a flu shot before? _____
- Are you sick today?
- Are you allergic to anything (latex, eggs, thimerosal, foods, medications, vaccines), etc? _____
- Do you have cancer, leukemia, HIV/AIDS, or any other immune system problems?
- Do you take cortisone, prednisone, steroids, anticancer drugs or x-ray treatments? _____
- Do you have a history of Guillain-Barré syndrome or an active neurological disorder?

ACKNOWLEDGEMENT

- I have received and read the Vaccine Information Statement (VIS) for the Influenza Vaccine, which explains the risks and benefits. I have had the chance to ask questions before vaccination. I understand that dependents under the age of 20 will have their vaccination entered into the Michigan Care Improvement Registry.
- I agree to remain under observation for at least 15 minutes. Should I leave before that period lapses, I expressly release McLaren Visiting Nurse & Hospice from any liability resulting from any adverse reaction to the vaccine which may occur during that period and thereafter. If any problems occur after I leave the facility, I am to call my physician or seek immediate care if necessary and to notify McLaren Visiting Nurse & Hospice (866-800-0135) of any reactions.
- I agree to release and hold harmless McLaren Health Care Corporation, McLaren Visiting Nurse & Hospice, its employees, agents and assigns from any and all liability associated with the treatment provided.
- I am aware that a copy of the HIPAA Privacy Notice for McLaren Visiting Nurse & Hospice is available upon request.
- I request that this provider be paid authorized Insurance and/or Medicare benefits on my behalf for any services furnished to me. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.
- **I understand that I am responsible for ANY charges NOT covered by my insurance.**

Signature: _____ **Date:** _____

(Parent or Legal Guardian if under 18 years / Relationship)

Clinic Use Only Accept assignment: YES NO

Medicare:

Medicare Part B BCBS Medicare Plus Blue BCBS Medicare Advantage BCN Advantage HP Medicare Plus

Contract # _____ Part B Effective Date: _____

Other Insurance: Accept assignment: YES NO

Blue Care Network Bay Health Plan Genesee Health Plan Health Advantage HAP Health Plus
 HP Partners HP Options McLaren Health Plan Physicians Health Plan Priority Health Plan Other: _____

Subscriber Name: _____ Subscriber DOB: _____

Contract # _____

Nurse Use Only:

Injection Site: R / L Deltoid Dose: 0.5ml Route: IM VIS Publication Date: _____
(circle one)

Manufacturer: _____ Lot #: _____ Expiration Date: _____

Nurse Signature: _____ Date: _____ Facility: _____