

McLaren Visiting Nurse & Hospice  
 Bay  Flint/Lapeer  Lansing  Sterling Hghts.

**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
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a problem with a flu shot before? _____
<input type="checkbox"/>	<input type="checkbox"/>	Are you sick today?
<input type="checkbox"/>	<input type="checkbox"/>	Are you allergic to anything (latex, eggs, thimerosal, foods, medications, vaccines), etc? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have cancer, leukemia, HIV/AIDS, or any other immune system problems?
<input type="checkbox"/>	<input type="checkbox"/>	Do you take cortisone, prednisone, steroids, anticancer drugs or x-ray treatments? _____
<input type="checkbox"/>	<input type="checkbox"/>	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 understand that it is strongly recommended that I remain in the facility for 15 minutes after vaccination to be observed for immediate reactions. 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 HIPPA 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

Are you covered by the Black Lung program? YES  NO  Are you currently on kidney dialysis? YES  NO

Are you currently employed? YES  NO  Under 65? YES  NO

MEDICARE (number and letter): \_\_\_\_\_ Effective date of Part B \_\_\_\_\_

Other Insurance: \_\_\_\_\_  
 (subscriber name and ID #)

**For 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: \_\_\_\_\_