INFLUENZA IMMUNIZATION CONSENT

LECOM INSTITUTE FOR SUCCESSFUL AGING | 5535 Peach St., Erie, PA 16509 · (814) 868 - 3883

SCREENING QUESTIONNAIRE FOR INJECTABLE INFLUENZAVACCINE

1. Has the Vaccine Information Statement on Influenza been made available to you?	**YES**	**NO**
2. Do you have a fever today?	**YES**	**NO**
3. Are you allergic to eggs or Thimerosal?	**YES**	**NO**
4. Have you ever had a serious reaction to a vaccine in the past?	**YES**	**NO**
5. Do you have a history of Guillain-Barre' syndrome? (If so, client should talk to doctor before receiving a flu shot)	**YES**	**NO**

☐ **By checking this box, I give LECOM Institute for Successful Aging permission to contact me by email and add me to their email list. Email:** _____

NAME OF PERSON RECEIVING VACCINE: _____ DOB:_____

Please circle

ADDRESS:_____ Over 65 Under 65
STREET

_____ TOWNSHIP:_____
CITY / STATE / ZIP

PHONE: _____ SSN: _____

FAMILY DR: _____

DR. PHONE/FAX: _____

☐ **By checking this box, I give LECOM Institute for Successful Aging permission to release this form to my family doctor.**

PRIMARY INSURANCE

NAME: _____ MEMBER ID: _____ GROUP NUMBER: _____

SECONDARY INSURANCE

NAME: _____ MEMBER ID: _____ GROUP NUMBER: _____

_____
CARDHOLDER NAME AND DATE OF BIRTH (IF NOT PERSON RECEIVING VACCINATION)

AMOUNT PAID: _____

CONSENT: **I authorize payment** for approved Medical Benefits be made on my behalf to LECOM Institute for Successful Aging for services furnished me by the physician/supplier. **I consent to the use and/or disclosure of my health information consistent with LECOM Institute for Successful Aging Privacy Practice Policies** of which a copy has been made available to me. I have read, or had explained, the above information. I hereby release LECOM Institute for Successful Aging and its agents from any and all claims of damage, loss, or liability arising out of administration of this vaccine. **I consent to be vaccinated or give consent for vaccination for the person named for whom I am legally authorized to give this consent.**

SIGNATURE OF RESPONSIBLE PARTY:_____ DATE: _____

**** PLEASE NOTE: YOU ARE RESPONSIBLE FOR PAYMENT IF YOUR INSURANCE DOES NOT PAY ****

On your explanation of benefits, Dr. James Lin, Medical Director, will be listed as the Medical Provider.

VACCINE	DATE ADMINISTERED	ADMINISTERED BY	INJECTION SITE	VACCINE INFORMATION *Place sticker here*
☐ FLUZONE HD ☐ FLUZONE QUADRIVALENT ☐ FLUCELVAX			☐LEFT DELTOID ☐RIGHT DELTOID	Lot: _____ Expiration: _____ Manufacturer: _____

CLINIC SITE: _____ **COORD INTIALS:** _____