Please Print Clearly

FLU VACCINE CONSENT

Date: _____

PATIENT INFORMATION

Name: _____ SS#: _____-___-_____ Sex (circle one): M F
Last First M. Initial

Address: _____ City: _____ State: _____ Zip: _____

Date Of Birth: ____/____/_____ Age: _____ Phone Number: (____)_____

INSURANCE INFORMATION

Insurance Company: _____ Contract/Member Identification #: _____ Group #: _____

Name of Primary Insured Card Holder: _____ Primary Insured Card Holder's Date of Birth: ____/____/_____

Primary Card Holder's Relationship to Patient: _____ Primary Insured Card Holder's SS#: _____-___-_____

CONSENT FOR INFLUENZA VACCINE

- I, the undersigned, give my consent to receive an influenza vaccination.
- I understand that occasionally some of the following symptoms may occur following the administration of this vaccine:
  - Slight redness, swelling and/or soreness at injection site for 1-2 days
  - Fever, tiredness, body aches (flu-like symptoms)
- To the best of my knowledge I ***DO NOT*** have an allergy to egg, egg products or Thimersol and I ***DO NOT*** have a fever (>99.6).
- I have been offered the Vaccine Information Sheet from the CDC.
- I understand that the flu vaccine may not be a covered charge by my insurance carrier. If this is the case, I will be responsible for the charge.

_____ ____/____/_____
Signature of Patient (Guardian) Date

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Office Use Only – Please fill all of this out

0.5 mL given in (circle one): **L Deltoid** or **R Deltoid**
Circle the vaccine given:

90674 *prefilled quad Flucelvax NDC 70461-0320-03 Lot 279828 exp 06/2021*

90460 *admin up to 18 years old*
90471 *admin 18 years old and up*
G0008 *Medicare admin*

_____
Administered By