

FLU VACCINE CONSENT FORM

RECIPIENT: Last _____ First _____ DOB _____

Facility Name _____ Recipient Resident Non-Resident Gender M F

NON-RESIDENT ONLY

- *MUST provide a copy of valid insurance card at time of vaccination*
- *If administered dose is not covered by insurance, facility will be billed for dose and administration*
- *Complete address is also required below*

Home Address _____ City _____

ST _____ ZIP _____ County _____ Phone _____

RESIDENTS

- *Who do not get their medications from Forum Pharmacy MUST provide a copy of valid insurance card at time of administration*
- *If administered dose is not covered by insurance, facility will be billed for dose and administration fee*

Insurance Plan Name _____ Group# _____ ID# _____

SSN _____ DL/State ID# _____ Medicare ID# _____

Screening Questions (Please check appropriate boxes)

Sick or feverish today?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Allergic to eggs, egg proteins, egg products, or any ingredient in the vaccine?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Breastfeeding, pregnant, or expect to become pregnant within the next month?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Immunocompromised due to a disease or therapy (such as cortisone, steroids, immunosuppressants, theophylline, warfarin, phenytoin)?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Received another type of vaccine within the last 30 days?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Ever had a serious reaction to the influenza vaccination?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Had Guillain-Barré syndrome?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

CONSENT

I consent to the administration of the Flu vaccine by a pharmacist or other authorized person employed or contracted by Forum Extended Care Services for which I am due or eligible to receive. I have received and read the current CDC Vaccine Information Statement about Flu. I have had a chance to ask questions and have had the opportunity to have all my questions answered to my satisfaction. I understand the benefits and risks of the Flu vaccine and request that the vaccine be given to me or to the person named above for whom I am authorized to make the request. I authorize the release of any medical information or other information necessary to process an insurance claim and for other health care operations. I understand that, if applicable, a claim will be submitted on my behalf to Medicare or my insurance plan. I authorize disclosure of vaccination information to public health officials, state immunization registry and/or other health care professionals. I, as well as the patient and his or her heirs, executors, personal representatives, and assigns, will not hold the above-named healthcare facility or facility nursing staff liable for any harm caused by my receiving Flu vaccine and waive any claim for damages that I may have against said facility, its directors, officers, employees, agents, or business associates on account of any loss, injury, death or damage I may suffer as a result of receiving the Flu vaccine. I have been advised to remain near vaccination area for observation for 15-30 minutes. I certify that I am the patient and am of legal age, or the patient's guardian/personal representative signing on behalf of the patient and have read, understand, and agree to all statements on this form.

Recipient Signature _____ Date _____

If other than resident, authorized representative's name (print): _____ Signature _____ Date _____

FOR HEALTHCARE PROFESSIONAL USE ONLY

Reviewed patient information and screening questions Initials: _____
 Confirmed patient's name, DOB, and requested vaccine Initials: _____
 Provided recipient/caregiver(s)/facility representative the VIS Initials: _____ Date on VIS Sheet _____

Product	Lot #	Expiration Date	Site of Administration IM
<input type="checkbox"/> Fluzone Trivalent 0.5 ml			<input type="checkbox"/> L-ARM <input type="checkbox"/> L-THIGH
<input type="checkbox"/> Fluzone High-Dose 0.7 ml			<input type="checkbox"/> R-ARM <input type="checkbox"/> R-THIGH
<input type="checkbox"/> Flublok Trivalent Egg-Free 0.5 ml			

Administration Date _____ Name of Vaccine Administration Company: _____

Immunizer's Name (Print) _____ Signature _____ Title _____

License #: _____ NPI# _____



FAX TO: 800-447-7167