FLU VACCINE CONSENT FORM

Forum EXTENDED CARE SERVICES

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)

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

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
☐ Fluzone Trivalent 0.5 ml ☐ Fluzone High-Dose 0.5 ml ☐ Flublok Trivalent Egg-Free 0.5 ml			☐ L-ARM ☐ L-THIGH ☐ R-ARM ☐ R-THIGH

Administration Date ________________ Name of Vaccine Administration Company:________________________

Immunizer's Name (Print) ________________________ Signature ________________________ Title ____________

License #:________________________ NPI#________________________

FAX TO: 800-447-7167