INFLUENZA IMMUNIZATION CONSENT FORM 2021-2022

Patient Information

Full Name: _____ **Birth date**: _____/_____/_____

SSN: ___ ___ ___ - ___ ___- ___ ___ ___ ___ **Phone**: _____

Address on File with Insurance/Medicare: **Street** _____

City/State _____,_____ **ZIP**_____

Do you have insurance? ☐ No ☐ Yes

Medicare Information

(Please fill in even if you have a Medicare Advantage Plan)

Medicare # _____

Name as it appears on your

Medicare Card (Red, White and Blue card): _____

INSURANCE INFORMATION

(Please bring ALL insurance cards to appointment)

Prescription Insurance Carrier: _____

Cardholder's Name: _____

Group No: _____

Policy No: _____

Relationship to cardholder: _____

Other Insurance: _____

Cardholder's Name: _____

Group No: _____

Policy No: _____

Relationship to cardholder: _____

The above information is true to the best of my knowledge. If qualified, I authorize billing to my insurance company and release of information required to process my claims.

I authorize my insurance benefits be paid directly to Phoebe Services Pharmacy.

Print Name, if different from patient: _____ Relationship:_____

Patient/POA Signature: _____Date: _____

PHOEBE PHARMACY

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I, the undersigned, wish to receive a vaccination against influenza. I am taking this vaccine voluntarily and consent to the vaccination being given to me. I have read the information provided. I understand the risks and benefits of this vaccine. I have had an opportunity to ask questions which have been answered to my satisfaction. I hereby waive any claim for damages that I (or anyone claiming on my behalf) may have against Phoebe Services Pharmacy, its directors, employees, and agents on account of any injury or misfortune I may suffer as a result of this vaccination. I authorize Phoebe Services Pharmacy to bill Medicare or my insurance for vaccine and administration. I understand that I may be responsible for any amount not covered by my insurance including Copays.

Patient Signature_____**Date**_____

Printed Name _____**DOB**_____

☐Resident ☐ Employee ☐Volunteer ☐ Other:_____

Pregnancy Policy:

The Centers for Disease Control and Prevention recommends Influenza Vaccine for women who will be beyond the first trimester of pregnancy during the influenza season because of the increased risk for influenza-related complications. Phoebe Ministries will administer the influenza vaccine in accordance with CDC recommendations and the employee's consent.

Please answer the following questions for professional review:

Do you have a serious allergy to chicken, egg or egg product?	Yes	No
Have you ever had a serious reaction after receiving a flu shot?	Yes	No
Are you pregnant or think you may be?	Yes	No
Are you sick today with a fever greater than 100.4?	Yes	No
Do you have any active neurologic disease?	Yes	No
Have you ever had Guillain-Barre Syndrome?	Yes	No

For Clinic/Office Use Only

Vaccine was administered IM on ____/_____/_____ Temp:

Vaccine Manufacturer and Dose:

Lot # and Expiration Date:

Site: RD or LD Administered by:_____

PHOEBE PHARMACY