

Influenza Immunization Consent Form 2018-2019



PLEASE PRINT CLEARLY – form must be completed to receive a flu shot

Do you have Medicare/Medicare Advantage? Y N

EMPLOYER NAME: _____

BILL INSURANCE (FILL OUT INSURANCE INFO BELOW) BILL EMPLOYER MEDICARE WAIVER SIGNED

LAST NAME: _____ **FIRST NAME:** _____ **MI:** _____

Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	DOB: _____ <input type="checkbox"/> \sqrt if under 18	Ph#: ()
Address (Street, City, State, Zip): _____		

Have you ever had:

Nurse Comments

Life threatening reaction to a flu shot	<input type="checkbox"/> Y <input type="checkbox"/> N	
Guillain-Barre Syndrome	<input type="checkbox"/> Y <input type="checkbox"/> N	
Severe allergy to eggs	<input type="checkbox"/> Y <input type="checkbox"/> N	
Are you currently ill with a fever?	<input type="checkbox"/> Y <input type="checkbox"/> N	

Insurance Information: Responsible Party if payment denied by Insurance: Employee Employer

MODA Regence Blue Cross Pacific Source Providence

Insured Name: Self _____ **Relationship:** _____

ID#: _____ **GROUP#:** _____ **Insured DOB:** _____

I have read/had explained to me the information about influenza and influenza vaccine (VIS 08/07/15). I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I agree that neither Cascade Health nor their sponsor shall have any responsibility or liability if I contract influenza, or other respiratory diseases, or suffer any other adverse reaction following administration of the flu shot. By signing below, I consent to the release of this consent form to my employer/insurance company for billing purposes; unless I am paying for the vaccination myself then no release is necessary.

Signature: _____ **Date:** _____

CLINIC USE ONLY

Fed Tax ID	93-0421470		Clinic Location: Cascade Health		
NPI#	1477714467	MFG:	GSK	Sanofi	
CPT (Vaccine)	90686	LOT#:	<input type="checkbox"/> 4ZY53 exp.06/30/19	<input type="checkbox"/> UT6261KA exp. 06/30/19	<input type="checkbox"/>
CPT (Admin)	90471	LOT#:	<input type="checkbox"/> JZ3B7 exp.06/30/19	<input type="checkbox"/>	<input type="checkbox"/>
Dx Code	Z23	LOT#:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Charge	\$32.00		Injection Site: <input checked="" type="checkbox"/> IM <input type="checkbox"/> R Upper Deltoid <input type="checkbox"/> L Upper Deltoid		

- | | | | |
|-----------------------------------------------|-----------------------------------------------------|--------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Abundez, Jessica MOA | <input type="checkbox"/> Hatton, JoAnn RN | <input type="checkbox"/> Cline, Curtis MOA | <input type="checkbox"/> deBroekert, Martha RN |
| <input type="checkbox"/> Feldman, Cindi RN | <input type="checkbox"/> Galbraith-Bain, Deanne MOA | <input type="checkbox"/> Johnson-Gibson, Lindsey | <input type="checkbox"/> Lopez, Roxye MOA |
| <input type="checkbox"/> Marks, Carla RN | <input type="checkbox"/> Mueller, Jan RN | <input type="checkbox"/> Royer, Adrienne RN | <input type="checkbox"/> Rowe, Laurie RN |
| <input type="checkbox"/> Sanborn, Wendy RN | <input type="checkbox"/> Swan, Whitney MOA | <input type="checkbox"/> Kehl, Jennifer, RN | <input type="checkbox"/> Other: _____ |