Influenza Immunization Consent Form 2021-2022

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

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

Gender: ☐ M ☐ F ☐ Other	**DOB:** ☐ √ **if under 18**	**Ph#:** ( )
Address (Street, City, State, Zip):		

Have you ever had:		**Nurse Comments**
Life threatening reaction to a flu shot	☐ Y ☐ N	
Guillain-Barre Syndrome	☐ Y ☐ N	
Severe allergy to eggs	☐ Y ☐ N	
Are you currently ill with a fever?	☐ Y ☐ N	

Signature:_____ **Date:**_____

COMPANY NAME:_____

☐ **BILL INSURANCE (FILL OUT INSURANCE INFO BELOW)** ☐ **BILL COMPANY**

Insurance Information: Responsible Party if payment denied by insurance: ☐ **Employee** ☐ **Company**

☐ **HMA** ☐ **MODA** ☐ **Kaiser** ☐ **Regence Blue Cross** ☐ **Pacific Source** ☐ **Providence**

☐ **Medicare/Med Advantage plan** ☐ **Other List Name:**_____

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

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

I have read/had explained to me the information about influenza and influenza vaccine (VIS 08/6/21). 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 authorizedto 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.

CLINIC USE ONLY					
Fed Tax ID	93-0421470		**Clinic Location:** Cascade Health		
NPI#	1477714467	**MFG:**	**GSK**		**Date Given**
CPT (Vaccine)	90686	**LOT#:**	☐ 9XX32	Exp. 6/30/22	
CPT (Admin)	90471	**LOT#:**	☐ 3477H	Exp. 6/20/22	
Dx Code	Z23	**LOT#:**	☐	Exp.	
Charge	$32.00	**LOT#:**	☐	Exp.	
			Injection Site: ☒ IM ☐ R Upper Deltoid ☐ L Upper Deltoid		

☐ Adolf, Sarah RN
☐ Anderson, Ann RN
☐ Borland, Lisa EMT
☐ Chavez, Jessica MOA
☐ Cline, Curtis MOA
☐ Dochnahl, Annie RN
☐ Dutton, Becky RN
☐ Flume, Katie MOA
☐ Galbraith-Bain,Deanne MOA
☐ Gerhart, Ben MOA
☐ Hassenger, Kim RN
☐ Johnson, Elysia MOA
☐ Kehl, Jennifer RN
☐ Knowlton, Karen RN
☐ Malmgren, Jim EMT
☐ Marks, Carla RN
☐ Paschell, Rebecca RN
☐ Potter, Melanie MOA
☐ Sahara, Mary Joy RN
☐ Selander, Trevor MOA
☐ Schrank, Jan RN
☐ Smith, Tanner EMT
☐ Spear, Sheila RN
☐ Swan Elder, Whitney MOA
☐ Vait, Rita RN
☐