Influenza Consent Form

1.	Do you feel sick today or have a fever?	YES	NO
2.	Are you allergic to Eggs, Bovine Protein, Gelatin, Gentamicin, Polymyxin, Neomycin, Phenol or Thimerosal?	YES	NO
3.	Have you had any vaccinations in the past 4 weeks?	YES	NO
4.	Have you ever had a serious reaction to any vaccine?	YES	NO
5.	Have you ever had Guillain-Barre Syndrome (GBS)? (illness associated with the swine flu in 1976 characterized by fever, nerve damage, and muscle weakness)	YES	NO
6.	Are you 65 years of age or older OR do you smoke OR have a chronic condition (such as asthma or diabetes)?	YES	NO
7.	If you answered YES to question #6, have you ever had a pneumococcal or “Pneumonia” vaccination?	YES	NO
8.	FOR WOMEN: Are you pregnant?	YES	NO
9.	FOR FLUMIST ONLY: Do you have a condition or are you taking medication which compromises your immune system?	YES	NO

Verified by: _____

I have read or have had explained to me the information about influenza vaccine. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risk of influenza vaccine and request that the vaccine be given to me or the person named below for whom I am authorized to make this request. I accept responsibility for seeking medical attention for any problems associated with this vaccination. I have been advised to wait at least 10 minutes before leaving this flu clinic.

I understand that I will be responsible for the cost, if Medicare, Medicaid, or any other Third Party Insurance does not cover this vaccination.

_____ _____

Signature Date

Please Complete Information on Back of Page

Please ***Legibly*** Print Your ***FULL*** Name and Address

Name_____
Last First Middle Initial

Address_____
Street City,State Zip

Phone Number_____ **Birthdate**_____/_____/_____
Month Day Year

Sex: Male _____ **Female** _____ **Info Verified with Drivers License** ☐

Circle Payment Source:

1. Cash/Check/Credit Card……$25.00 Fee

2. Supermarket Employee (billed to No Frills)…….....NO FEE

3. Medicare: Please circle what type of Medicare Insurance you have and present your Medicare Part B identification card to the staff member. Your information above must match your card.

a. Medicare – Part B _____**..... NO FEE**

b. Railroad-Medicare Part B _____**..... NO FEE**

4. Blue Cross Blue Shield _____**..... NO FEE**

5. Nebraska Medicaid with Diagnosis Code _____**..... NO FEE**

6. FluMist: Cash/Check/Credit Card……...$35.00 Fee

For Health Mart Pharmacy USE ONLY: Clinic Location: _____

Date Vaccinated: _____ Site of Injection RD LD

Mfr: _____ Lot#: _____ Exp Date: _____

Administered By: _____ Date VIS Given: _____