INFLUENZA IMMUNIZATION CONSENT
LECOM CENTER FOR HEALTH AND AGING

3910 Schaper Ave Erie PA 16508 · (814) 812 - 7202

SCREENING QUESTIONNAIRE FOR INJECTABLE INFLUENZA VACCINE

Question		
1. Has the Vaccine Information Statement on Influenza been made available to you?	**YES**	**NO**
2. Do you have a fever today?	**YES**	**NO**
3. Are you allergic to eggs or Thimerosal?	**YES**	**NO**
4. Have you ever had a serious reaction to a vaccine in the past?	**YES**	**NO**
5. Do you have a history of Guillain-Barre' syndrome? (If so, client should talk to doctor before receiving a flu shot)	**YES**	**NO**

☐ **By checking this box, I give LECOM Center for Health and Aging permission to contact me by email and add me to their email list Email:** ______________________________

NAME OF PERSON RECEIVING VACCINE: ______________________________ DOB:__________________

Please circle
Over 65 Under 65

ADDRESS:____
STREET

____ TOWNSHIP:__________________
CITY / STATE / ZIP

PHONE: ______________________ SSN: ______________________

FAMILY DR: ______________________________

DR. PHONE/FAX: ______________________________

☐ **By checking this box, I give LECOM Center for Health and Aging permission to release this form to my family doctor.**

PRIMARY INSURANCE
NAME: __________________ MEMBER ID: __________________ GROUP NUMBER: __________________

SECONDARY INSURANCE
NAME: __________________ MEMBER ID: __________________ GROUP NUMBER: __________________

____
CARDHOLDER NAME AND DATE OF BIRTH (IF NOT PERSON RECEIVING VACCINATION)

AMOUNT PAID: ____________

CONSENT: **I authorize payment** for approved Medical Benefits be made on my behalf to LECOM Center for Health and Aging for services furnished me by the physician/supplier. **I consent to the use and/or disclosure of my health information consistent with LECOM Center for Health and Aging Privacy Practice Policies** of which a copy has been made available to me. I have read, or had explained, the above information. I hereby release LECOM Center for Health and Aging and its agents from any and all claims of damage, loss, or liability arising out of administration of this vaccine. **I consent to be vaccinated or give consent for vaccination for the person named for whom I am legally authorized to give this consent.**

SIGNATURE OF RESPOSIBLE PARTY:______________________________ **DATE:** __________________

**** PLEASE NOTE: YOU ARE RESPONSIBLE FOR PAYMENT IF YOUR INSURANCE DOES NOT PAY ****

On your explanation of benefits, Dr. James Lin, Medical Director, will be listed as the Medical Provider.

VACCINE	DATE ADMINISTERED	ADMINISTERED BY	INJECTION SITE	VACCINE INFORMATION *Place sticker here*
☐ FLUZONE HD ☐ FLUCELVAX ☐ FLUZONE QUADRIVALENT			☐LEFT DELTOID ☐RIGHT DELTOID	Lot: ____________ Expiration: ____________ Manufacturer: ____________

CLINIC SITE: ______________________ **COORD INTIALS:** ______________________