

# ADULT INFLUENZA IMMUNIZATION CONSENT

LECOM INSTITUTE FOR SUCCESSFUL AGING | 5535 Peach St., Erie, PA 16509 · (814) 868 - 3883

## SCREENING QUESTIONNAIRE FOR INJECTABLE INFLUENZA VACCINE

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

By checking this box, I give LECOM Institute for Successful Aging permission to contact me by email and add me to their email list.

NAME OF PERSON RECEIVING VACCINE: \_\_\_\_\_

DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

**Please circle**

Over 65    Under 65

STREET

CITY / STATE / ZIP

PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

### 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 Institute for Successful Aging for services furnished me by the physician/supplier. **I consent to the use and/or disclosure of my health information consistent with LECOM Institute for Successful 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 Institute for Successful 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 RESPONSIBLE PARTY:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

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

Please be aware your claim for today's services will process as: LECOM Senior Living Center (Millcreek Manor), Dr. James Y. Lin.

QUADRIVALENT VACCINE	DATE ADMINISTERED	ADMINISTERED BY	INJECTION SITE	VACCINE INFORMATION *Place sticker here*
<input type="radio"/> FLUZONE HIGH DOSE <input type="radio"/> FLUZONE <input type="radio"/> FLUBLOK			<input type="checkbox"/> LEFT DELTOID <input type="checkbox"/> RIGHT DELTOID	Lot: _____ Expiration: _____ Manufacturer: _____

**CLINIC SITE:** \_\_\_\_\_ **COORD INTIALS:** \_\_\_\_\_

Quadax Real-Time Eligibility:

Active: \_\_\_\_\_

Inactive: \_\_\_\_\_

Override Approved: \_\_\_\_\_