PEDIATRIC INFLUENZA IMMUNIZATION CONSENT (For under 18-years or legal guardian)
LECOM INSTITUTE FOR SUCCESSFUL AGING | 5535 Peach Street, Erie, PA 16509 · (814) 868 - 3883

SCREENING QUESTIONNAIRE FOR INJECTABLE INFLUENZAVACCINE

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? **YES** **NO**
   (If so, client should talk to doctor before receiving a flu shot)

NAME OF PERSON RECEIVING VACCINE: ______________________ DOB:______________

ADDRESS:____
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 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.**

NAME OF RESPONSIBLE PARTY (print): ______________________RELATIONSHIP: ____________

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*
o FLUZONE			☐ LEFT DELTOID ☐ RIGHT DELTOID	Lot: ____________ Expiration: __________ Manufacturer: ________

1ST WITNESS SIGNITURE: ________________ 2ND WITNESS SIGNITURE: ________________

CLINIC SITE: ______________________ COORD INTIALS: __________

Quadax Real-Time Eligibility:
Active: ________
Inactive: ________
Override Approved:
____