

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? | 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)

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

NAME OF PERSON RECEIVING VACCINE: _____ DOB: _____

ADDRESS: _____ **Please circle**
Over 65 Under 65

STREET

TOWNSHIP: _____

CITY / STATE / ZIP

PHONE: _____ SSN: _____

FAMILY DR: _____

DR. PHONE/FAX: _____

By checking this box, I give LECOM Institute for Successful 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 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: _____