INFLUENZA IMMUNIZATION CONSENT
LECOM CENTER FOR HEALTH AND AGING

3910 Schaper Ave Erie PA 16508 · (814) 453-5072

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 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

ADDRESS: _____ Over 65 Under 65

STREET / CITY / STATE / ZIP

PHONE: _____ SSN: N/A

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:** _____

August 2020