# Influenza Immunization Consent Form 2019-2020

**PLEASE PRINT CLEARLY – *form must be completed to receive a flu shot***

**Do you have Medicare/Medicare Advantage?** ☐ Y ☐ N

**EMPLOYER NAME:**_____

☐ **BILL INSURANCE** *(FILL OUT INSURANCE INFO BELOW)* ☐ **BILL EMPLOYER** ☐ **MEDICARE WAIVER SIGNED**

**LAST NAME:**_____ **FIRST NAME:**_____ **MI:**_____

| | | |
|---|---|---|
| **Gender:** ☐ M ☐ F ☐ Other | **DOB:** ☐ √ **if under 18** | **Ph#:** ( ) |
| **Address (Street, City, State, Zip):** | | |

| **Have you ever had:** | | **Nurse Comments** |
|---|---|---|
| Life threatening reaction to a flu shot | ☐ Y ☐ N | |
| Guillain-Barre Syndrome | ☐ Y ☐ N | |
| Severe allergy to eggs | ☐ Y ☐ N | |
| Are you currently ill with a fever? | ☐ Y ☐ N | |

**Insurance Information: Responsible Party if payment denied by insurance:** ☐ **Employee** ☐ **Employer**

☐ **MODA** ☐ **Regence Blue Cross** ☐ **Pacific Source** ☐ **Providence**

**Insured Name:** ☐ **Self** _____ **Relationship:**_____

**ID#:**_____ **GROUP#:**_____ **Insured DOB:**_____

I have read/had explained to me the information about influenza and influenza vaccine (VIS 08/15/2019). I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or to the person named above for whom I am authorizedto make this request. I agree that neither Cascade Health nor their sponsor shall have any responsibility or liability if I contract influenza, or other respiratory diseases, or suffer any other adverse reaction following administration of the flu shot. By signing below, I consent to the release of this consent form to my employer/insurance company for billing purposes; unless I am paying for the vaccination myself then no release isnecessary.

**Signature:**_____ **Date:**_____

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| **CLINIC USE ONLY** | | | | | |
|---|---|---|---|---|---|
| **Fed Tax ID** | 93-0421470 | | **Clinic Location:** Cascade Health | | |
| **NPI#** | 1477714467 | **MFG:** | **GSK** | **Sanofi** | **Date Given** |
| **CPT (Vaccine)** | 90686 | **LOT#:** | ☐ 72L29 Exp. 06/30/20 | ☐ | / /2019 |
| **CPT (Admin)** | 90471 | **LOT#:** | ☐ | ☐ | / /2019 |
| **Dx Code** | Z23 | **LOT#:** | ☐ | ☐ | / /2019 |
| **Charge** | $32.00 | | **Injection Site:** ☒ IM ☐ R Upper Deltoid ☐ L Upper Deltoid | | |

☐ Abundez, Jessica MOA ☐ Bravo-Meyer, Nancy RN ☐ Cline, Curtis MOA ☐ deBroekert, Martha RN
☐ Feldman, Cindi RN ☐ Galbraith-Bain, Deanne MOA ☐ Johnson-Gibson, Lindsey ☐ Kehl, Jennifer, RN
☐ Kinder, Carissa RN ☐ Lopez, Roxye MOA ☐ Marks, Carla RN ☐ Mueller, Jan RN
☐ Rowe, Laurie RN ☐ Royer, Adrienne RN ☐ Sahara, Mary Joy RN ☐ Swan, Whitney MOA
☐ Other: _____