

Influenza Immunization Consent Form 2021-2022



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

LAST NAME: _____ FIRST NAME: _____ MI: _____

Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	DOB: _____ <input type="checkbox"/> \sqrt if under 18	Ph#: ()
Address (Street, City, State, Zip): _____		

Have you ever had:		Nurse Comments
Life threatening reaction to a flu shot	<input type="checkbox"/> Y <input type="checkbox"/> N	
Guillain-Barre Syndrome	<input type="checkbox"/> Y <input type="checkbox"/> N	
Severe allergy to eggs	<input type="checkbox"/> Y <input type="checkbox"/> N	
Are you currently ill with a fever?	<input type="checkbox"/> Y <input type="checkbox"/> N	

Signature: _____ Date: _____

COMPANY NAME: _____

BILL INSURANCE (FILL OUT INSURANCE INFO BELOW) BILL COMPANY

Insurance Information: Responsible Party if payment denied by insurance: Employee Company

HMA MODA Kaiser Regence Blue Cross Pacific Source Providence

Medicare/Med Advantage plan Other List Name: _____

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 authorized to 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 is necessary.

CLINIC USE ONLY				
Fed Tax ID	93-0421470		Clinic Location: Cascade Health	
NPI#	1477714467	MFG:	GSK	Date Given
CPT (Vaccine)	90686	LOT#:	<input type="checkbox"/> 9XX32 Exp. 6/30/22	
CPT (Admin)	90471	LOT#:	<input type="checkbox"/> Exp.	
Dx Code	Z23	LOT#:	<input type="checkbox"/> Exp.	
Charge	\$32.00	LOT#:	<input type="checkbox"/> Exp.	
			Injection Site: <input checked="" type="checkbox"/> IM <input type="checkbox"/> R Upper Deltoid <input type="checkbox"/> L Upper Deltoid	

- | | | |
|---|---|--|
| <input type="checkbox"/> Adolf, Sarah RN | <input type="checkbox"/> Gerhart, Ben MOA | <input type="checkbox"/> Sahara, Mary Joy RN |
| <input type="checkbox"/> Anderson, Ann RN | <input type="checkbox"/> Hassenger, Kim RN | <input type="checkbox"/> Selander, Trevor MOA |
| <input type="checkbox"/> Borland, Lisa EMT | <input type="checkbox"/> Johnson, Elysia MOA | <input type="checkbox"/> Schrank, Jan RN |
| <input type="checkbox"/> Chavez, Jessica MOA | <input type="checkbox"/> Kehl, Jennifer RN | <input type="checkbox"/> Smith, Tanner EMT |
| <input type="checkbox"/> Cline, Curtis MOA | <input type="checkbox"/> Knowlton, Karen RN | <input type="checkbox"/> Spear, Sheila RN |
| <input type="checkbox"/> Dochnahl, Annie RN | <input type="checkbox"/> Malmgren, Jim EMT | <input type="checkbox"/> Swan Elder, Whitney MOA |
| <input type="checkbox"/> Dutton, Becky RN | <input type="checkbox"/> Marks, Carla RN | <input type="checkbox"/> Vait, Rita RN |
| <input type="checkbox"/> Flume, Katie MOA | <input type="checkbox"/> Paschell, Rebecca RN | <input type="checkbox"/> |
| <input type="checkbox"/> Galbraith-Bain, Deanne MOA | <input type="checkbox"/> Potter, Melanie MOA | |