2020 FLU VACCINATION CONSENT FORM

Last	*First*	*MI*	*DOB* _ _ / _ _ / _ _ _ _

Address	*City*	*State*	*Zip*

Phone	*Email*	*Gender* ☐ Male ☐ Female

Clinic Location:

HEALTH INSURANCE INFORMATION

☐ Blue Cross Blue Shield (Federal or RI only) _____

☐ UnitedHealthcare ID# _____ Group #_____

☐ Medicare_____

☐ Neighborhood Health Plan _____

☐ Tufts_____

☐ Cigna/Carelink_____

☐ Cigna Healthcare_____

☐ Different or No Insurance – *No Charge*

SCREENING FOR FLU INJECTABLE VACCINE	
Any serious allergy to eggs?	YES NO
Ever had a serious reaction to previous dose of flu vaccine that required medical attention?	YES NO
Ever had Guillain-Barre Syndrome (temporary severe muscle weakness) after receiving flu vaccine?	YES NO
Is there a possibility that the person receiving the vaccine is pregnant?	YES NO
ADDITIONAL SCREENING FOR FLUMIST VACCINE (ages 3-18 only) ***Limited Availability***	
Received the MMR and/or Varicella vaccine(s) within the past 28 days or any other live vaccine?	YES NO
Have asthma, diabetes, or disease of the lungs, heart, kidneys, liver, nerves, or blood?	YES NO
On long-term aspirin or aspirin-containing therapy (aspirin every day)?	YES NO
Have a weak immune system from HIV, cancer, or medications such as steroids or those used to treat cancer, or are in close contact with a person who needs care in a protected environment?	YES NO

CONSENT FOR VACCINATION

I have viewed the Vaccine Information Statement(s) at www.immunize.org or obtained a hard copy by calling the Rhode Island Department of Health (401-222-5960). I understand the benefits and risks of the vaccine.

The vaccine checked above should be given to the person named above for whom I am authorized to make this request. I understand that I can review a Notice of Privacy Practice at the time of registration. I hereby release *The Wellness Company* from any and all liability associated with the administration and potential side effects of the vaccine.

Signature of Parent/Guardian/Patient: _____

FOR ADMINISTRATIVE USE ONLY **VIS Date: 8/15/2019**

Vaccine	Route	Manufacturer	Lot No.	Date VIS Provided	Vaccination Date	Signature of Vaccine Administrator
Influenza	IM *R L* *Intranasal*					