CLEAR FORM

NEN/NEHHS Flu Consent and Information Sheet

PRINT

*Information about the person to receive vaccine (please print): *Required Fields*

Name (Last, First, MI)*	Date of Birth*	Age*	Sex*
	/ /		☐ Male ☐ Female
Street Address*			
City*	State*	Zip*	Phone*

Insurance Information: Include the whole member ID number and any letters that are a part of that number

Name of Insurance Company*	Member ID Number*	Group Number if available
Medicare Number	Is Medicare Primary?	Is Subscriber Retired?

If Person getting vaccinated is not the subscriber, please complete the following:

Subscriber's Name (Last, First, MI)*	Date of Birth*	Sex:
	/ /	☐ Male ☐ Female
Subscriber's Street Address* (If different from address above)		
City*	State*	Zip*	Phone*

Patient Relationship to Subscriber: (Check)* ☐ Spouse ☐ Child ☐ Other

Please check your answer on the right side of the page

1.	Is this the first flu shot you have ever had (in your life)? ……	☐ No	☐ Yes
2.	Do you have a temperature of 101.5° F or greater or are you sick today?.....	☐ No	☐ Yes
3.	Are you allergic to eggs, latex or Thimerosal?.....	☐ No	☐ Yes
4.	Have you ever been diagnosed with Guillain-Barré Syndrome?.....	☐ No	☐ Yes
5.	Do you take Coumadin or Warfarin?.....	☐ No	☐ Yes
6.	Have you ever had an allergic reaction or problem after a vaccination?.....	☐ No	☐ Yes
7.	Have you had a flu shot in the last three years?.....	☐ No	☐ Yes

PATIENT CONSENT I have read the adverse reactions associated with the Influenza vaccine. A copy of the vaccine manufacturer's drug information sheet is available on request. I have also had an opportunity to ask questions about this immunization. I believe that the benefits outweigh the risks and I assume full responsibility for any reactions that may result. I waive and release any and all claims I, or anyone claiming by or through me, now have or may hereafter acquire against NEN/NEHHS and the clinic site sponsor and their respective directors, officers, employees, and agents for any and all damages or injuries if I, or the person named below for whom I am authorized to make this request, contract Influenza, other respiratory diseases, or suffer any other adverse reactions following administration of this flu shot. **In the event of an anaphylactic reaction, I agree to have 1. Epinephrine 1:1000 strength (0.5 ml, maximum) intramuscular injection, repeated every 10-20 minutes until symptoms subside, up to a maximum number of 3 times 2. Administer diphenhydramine Dose Oral, 25 and 50 mg capsule or tab. Both of these treatments are in accordance with our signed standing order for emergency treatment. COVID-19 screening was done by my employer/myself prior to my influenza vaccine.** I understand that NEN/NEHHS can only bill certain insurances and that if I have an insurance NEN/NEHHS cannot bill, I am required to make payment to NEN/NEHHS at the time that services are provided unless other arrangements have been made. I have received a copy of the current Vaccine Information Statement created by the CDC.

I have read the above and give permission for my insurance company to be billed.

X _____ Date: _____

(Signature of patient or legal guardian)

For Clinic/Office Use Only:

Date of Service	Vax Type*					State Supplied	Preserv Free	Injection Route	Injection Site		Date on VIS
						No	No	IM	___ R arm ___ L arm		08-06-2021

* IIV4 is inactivated influenza vaccine quadrilvalent **The VIS form was provided prior to the clinic date and at the time of the clinic.**

Signature of Vaccine Administrator: _____ Date: _____

Provider Name: **NEN/NEHHS** MDPH Provider PIN # 23443

Provider Address: **594 Marrett Rd, Suite 11, Lexington, MA 02421 781 862-5600 781 674-8600**

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