1213 Garfield Ave.
Harlan IA 51537

Rev. 08/09, 09/09

2009-10 ADULT "SHOT" SEASONAL INFLUENZA VACCINATION ASSESSMENT & CONSENT

Last name __________________First name ________________Middle name__________

Address:____________________City:_________________State__________Zip_________

Date of Birth: _______________________________ Circle➔ Male or Female

Do you have a severe allergy to eggs, or to a previous flu shot? No
Or if yes, describe:____

Have you had Guillain-Barre (GBS) syndrome? No If you have had GBS, you may be able to get the vaccine but you should discuss it with your physician first.

I declare that:

- I am not sick with a fever today.
- I have not had a severe allergic reaction to a flu shot in the past.
- I am not allergic to eggs, egg products, egg protein or chicken protein.
- I have read the Influenza Vaccine Information Sheet, or have had the information explained to me.
- I have had a chance to ask questions & they have been answered to my satisfaction.
- I understand the benefits and risks of the flu shot, and ask that the flu shot be given to me (or to the person for whom I am authorized to make this request).
- I accept responsibility to seek medical attention if a problem occurs after this shot.
- I understand that vaccination with flu vaccine may not protect 100% of people from getting the flu.
- I allow billing to Medicare, my Medicare HMO, Medicaid, or have paid $30.00.

SIGNATURE X____________________________________ DATE X ________________

➔Please turn the sheet over and fill in the blanks for name and birth date only at the top➔

FOR OFFICE USE ONLY

Medicare #_________________ Medicare Part B? Circle➔ Yes or No

You must have Part B in order for "regular" Medicare to pay for the flu shot.

Is the Medicare plan a HMO? No____ or if Yes___ Name of HMO____________________

You must show us your Medicare HMO card if you want us to bill it. We will bill your HMO.
If your HMO denies our billing, we will bill you for $30.00.

&/or:

Are you eligible for Medicaid (Title 19) this month? Yes □

If yes, → Medicaid ID #_________________________ (*must show card*)

Paid $30.00? **circle➔ Cash or Check # _________ Receipt given____ (initials)____**

MYRTUE Medical Center
1213 Garfield Ave.
Harlan IA 51537
Rev. 08/09, 09/09

2009-10 ADULT "SHOT"
SEASONAL INFLUENZA VACCINATION
ASSESSMENT & CONSENT

Please print clearly:

Your name: ______________________________ **Your date of birth**________________________

**************************************_Stop here_: below this line for staff use** **

All persons should be assessed for contraindications to vaccines.

Assessment comments: ____

____

Assure that VIS (Vaccine Information Statement) dated 08/11/09 or later was given to client or responsible party.

Influenza Vaccination

Immunization Date	Manufacturer/Brand//Lot (ok to use sticker)	Dosage & Site	Vaccinator Signature
	GSK FLUARIX # AFLUA468AA expires: June 30, 2010	.5 ml IM *(circle)* L R Deltoid	

ENTERED INTO IRIS DATE/INITIALS_____________

Practice Partner___________