Rev 9/1/17

ADULT ONLY FLU VACCINE "SHOT"

2017-18 IMMUNIZATION SCREENING & CONSENT

Last name ____________________First name __________________Middle name__________

Address: ______________________City:_________________________State__________Zip_________

Date of Birth: _______________ Age: ________years Circle → Male or Female

Phone: ________________________________ Other phone:_________________

<u>I agree to the following:</u>

1. I agree to have my insurance billed; if the insurance does not pay the whole amount, I agree to pay the difference.
2. I have read or seen a copy of the Vaccine Information Sheet dated 8.7.15 or have had the information explained to me.
3. I understand the risks of the vaccination and request that the flu shot is given to me.
4. I accept responsibility for seeking medical attention for any problems with this vaccine.
5. The person getting the shot does not have a severe allergy to eggs.
6. The person getting the shot does not have a fever and is not moderately to severely ill at this time.
7. The person getting the shot has never had Guillain-Barre Syndrome.

SIGNATURE _____________________________________DATE______________________

***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 an HMO? *If so, we do not bill HMO's, give client a receipt to bill the HMO.*

Staple a copy of Wellmark card <u>or</u> BCBS Member Id#____________________________

Group # _____________________ BCBS Insured member name_________________________
Wellmark member's date of birth ________________

Regular Shot $37 High Dose $57

Paid $_________ (circle→) Cash or Check# ________ Receipt given by _____ *(initials)*

Or bill to: ____

Give/review influenza VIS (Vaccine Information Statement) dated 8/7/15 or later with each dose.

<u>For adults 19 years and older</u>

Immunization Date	Brand & Lot # (ok to use sticker)	Dosage, Route & Site *(circle)*	Vaccinator Signature
		0.5 ml IM **L deltoid** **R deltoid**	

Entered into IRIS initials________ date____________