MEDINURSE

Influenza Vaccination Consent

Your safety is our primary concern. MediNurse recommends you remain on premises for 10 minutes after receiving your vaccination. If you choose to leave the vaccination area, you are doing so against medical advice.

⇨ **PLEASE PRINT your name, address, age, date of birth, gender and phone number.**

First Name | MI | Last Name

Address Number | Street Name

City | State | Zip Code

Age | Date of Birth | Gender | Area Code | Phone Number

☐ Male
☐ Female

⇨ **PLEASE ANSWER the following questions:**

1. What is your/your child's age range? ☐ through age 8 ☐ age 9 thru 17 ☐ age 18 or over
2. Are you currently ill or running a fever? ..... ☐ Yes ☐ No
3. Are you pregnant or suspect so, or nursing? ..... ☐ Yes ☐ No
4. Have you had an allergic reaction to Thimerosal or contact solution? ..... ☐ Yes ☐ No
5. Do you have an allergy to eggs, egg products, or chicken protein? ..... ☐ Yes ☐ No
6. Do you have an allergy to latex? ..... ☐ Yes ☐ No
7. Do you have a prior history of Guillain-Barre Syndrome? ..... ☐ Yes ☐ No
8. Have you had a **REACTION** from a previous flu shot? ..... ☐ Yes ☐ No
9. Have you been instructed **NOT** to get a flu shot? ..... ☐ Yes ☐ No

Based on your responses to the above questions, the nurse may need to direct you to your physician to obtain your vaccination.

ASSIGNMENT OF BENEFITS

I authorize MediNurse, Inc. to obtain pertinent information, medical or otherwise, necessary to process this claim. I agree to pay the amount not paid if my charges are denied for any reason. I also agree to pay any collection fees if this account is sent to an outside company for collections. I have had an opportunity to read the "Notice of Privacy Practices" from MediNurse, Inc. I authorize MediNurse, Inc. the holders of medical information about me to release such information and medical records regarding my vaccination to Medicare, its intermediaries, carriers, peer review organization, insurance companies and other third party payers and their agents for benefit.

⇨ **Patient Initials** _____

OVER»»»»»»

I have read the Vaccine Information Statement and information about the flu vaccine has been explained. Any questions I may have were answered to my satisfaction and understanding. I am requesting the vaccination be administered to me or the person named for whom I am authorized to make this request. I am authorizing MediNurse, Inc. to initiate emergency treatment if needed. I also authorized MediNurse, Inc. to bill and receive payment for vaccinations administered today. MediNurse is hereby released from all legal liability that may arise from the release of information for the foregoing purposes and those stated in the "Notice of Privacy Practice". I understand that in order for any of my health information to be released, MediNurse requires a signed release of information form on file. I understand all the risks and benefits involved and have had a chance to ask questions.

I release MediNurse, Inc., its officers, employees, and affiliates from any and all liability that may arise from or in any way connected with the vaccines on behalf of my heirs, personal representatives and myself.

⇨ **By signing below I agree the above statements are true to the best of my knowledge.**

Patient/Guardian Signature _____ Date _____

PAYMENT

☐ **Employer Paid**

☐ **Insurance** My ***PRIMARY*** insurance carrier is: ☐ Medicare Part B ☐ Medicare Railroad ☐ Coventry

Insured Person's Name (Please print)	**Insurance ID Number (Note: Medicare must include *ID number + Letter*)**

☐ **Self Pay** using: ☐ Cash ☐ Check ☐ Credit Card Amount: _____

IF CREDIT CARD: Name as it appears on card:

Type of Card: ☐ Visa ☐ MasterCard ☐ Discover

Credit Card Number: 3-Digit Security Code: Expiration Date: mm yyyy

Signature: _____

Your signature authorizes us to charge your card for the amount indicated above. Information will not be kept beyond 60 days from date of purchase.

MEDINURSE USE ONLY ---- DO NOT WRITE BELOW THIS LINE

Filled in by Nurse: Clinic: _____ Clinic Date: _____

Influenza Mfg: ☐ Novartis/Seqirus ☐ Pregnancy Other: _____ Lot # _____ Exp _____

Injection Site: ☐ Deltoid ☐ Right ☐ Left ☐ Other Reason: _____

Nurse Signature: _____ Print Initials: _____ Date: _____