

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		
<input type="text"/>	<input type="text"/>	<input type="text"/>		
Address Number	Street Name			
<input type="text"/>	<input type="text"/>			
City	State	Zip Code		
<input type="text"/>	<input type="text"/>	<input type="text"/>		
Age	Date of Birth	Gender	Area Code	Phone Number
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="text"/>	<input type="text"/>

➡ **PLEASE ANSWER the following questions:**

- 1. Are you currently ill or running a fever? Yes No
- 2. Are you pregnant or suspect so, or nursing? Yes No
- 3. Have you had an allergic reaction to Thimerosal or contact solution? Yes No
- 4. Do you have an allergy to eggs, egg products, or chicken protein? Yes No
- 5. Do you have an allergy to latex? Yes No
- 6. Do you have a prior history of Guillain-Barre Syndrome? Yes No
- 7. Have you had a **REACTION** from a previous flu shot? Yes No
- 8. 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** _____

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 Check only if your **PRIMARY** insurance carrier is Medicare Part B

Insured Person's Name (Please print)

Medicare ID Number + Letter
(Note: Medicare must include *ID number + Letter*)

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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
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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 Loc: _____ Clinic Date: _____

Vaccine: Quadrivalent Preservative-Free Mfg: _____ Lot #: _____

Injection Site: Deltoid: Right Left Other: _____

Nurse Signature: _____ Print Initials: _____ Date: _____