INFLUENZA IMMUNIZATION CONSENT

LifeWorks Erie 406 Peach Street · Erie, PA 16507 · (814) 453-5072

SCREENING QUESTIONNAIRE FOR INJECTABLE INFLUENZA VACCINE

1. Has the Vaccine Information Statement on Influenza been made available to you?	**YES**	**NO**
2. Do you have a fever today?	**YES**	**NO**
3. Are you allergic to eggs or Thimerosal?	**YES**	**NO**
4. Have you ever had a serious reaction to a vaccine in the past?	**YES**	**NO**
5. Do you have a history of Guillain-Barre' syndrome? (If so, client should talk to doctor before receiving a flu shot)	**YES**	**NO**

☐ **By checking this box, I give LifeWorks Erie permission to contact me by email and add me to their email list.**

How did you hear about this flu shot location? _____

NAME OF PERSON RECEIVING VACCINE: _____ **BIRTH DATE:** _____

ADDRESS: _____ _____ _____ _____ **GENDER: M F**
Street City State Zip

PHONE: _____ **SOCIAL SECURITY:** _____-_____-_____ (Of person receiving vaccine)

FAMILY DR: _____ **ETHNIC: W B H OTHER** **EMAIL:** _____

● **PRIMARY INSURANCE** _____

_____ _____ _____ _____ _____
Insurance Address City State Zip Phone

_____ _____
Member ID from insurance card Group number

● **SECONDARY INSURANCE** _____

_____ _____ _____ _____ _____
Insurance Address City State Zip Phone

_____ _____
Member ID from insurance card Group number

_____ _____
Subscriber/ Name (If NOT Patient) Subscriber Date of Birth (If NOT Patient)

CONSENT: **I authorize payment** for approved Medical Benefits be made on my behalf to LifeWorks Erie for services furnished me by the physician/supplier. **I consent to the use and/or disclosure of my health information consistent with LifeWorks Erie Privacy Practice Policies** of which a copy has been made available to me. I have read, or had explained, the above information. I hereby release LifeWorks Erie and its agents from any and all claims of damage, loss, or liability arising out of administration of this vaccine. **I consent to be vaccinated or give consent for vaccination for the person named for whom I am legally authorized to give this consent.**

Signature of Responsible Party: _____ **Date:** _____

**** PLEASE NOTE: YOU ARE RESPONSIBLE FOR PAYMENT IF YOUR INSURANCE DOES NOT PAY ****

On your explanation of benefits, Dr. James Lin, Medical Director, will be listed as the Medical Provider.

☐ **Flucelvax** ☐ **Fluvirin** ☐ **Fluzone** ☐ **Disparate VACCINE LOT#:** _____ **EXP:** _____

NURSE SIGNATURE: _____ **INJECTION SITE:** _____

CLINIC SITE: _____ **REG. INITIALS:** _____ **AMOUNT PAID:** _____