Only use <u>BLACK INK</u>

Please print name in ALL CAPITAL LETTERS

A form must be completed for EACH person being vaccinated

Complete the Demographic Information section

Complete the Payment Information section
- **If paying with MasterCard or Visa, you must present your credit card the day of the clinic.**
- **If paying with Medicare Part B, Medicare Railroad, Medicaid, Aetna, Aetna Medicare, Caresource, United Health Care, Cigna, or The Health Plan, you must present your medical card the day of the clinic.**

Answer the questions in the Authorization section

Print the form (form cannot be saved)

Sign and Date

Bring completed form and credit card and/or medical card (if applicable)

*Flu*Stations® OH HD - Canton City Health Dept.

CLINIC ID: 1 0 1 0 9 3 8

CONSENT FOR VACCINATION

1) DEMOGRAPHIC INFORMATION

Please print name in ALL CAPITAL LETTERS and BLACK INK ONLY as it appears on your insurance card.

FIRST NAME: ☐☐☐☐☐☐☐☐☐☐☐☐

LAST NAME: ☐☐☐☐☐☐☐☐☐☐☐☐

DATE OF BIRTH: (MM/DD/YYYY)

GENDER: ☐ M ☐ F

MIDDLE INITIAL: ☐

LAST 4 SSN: ☐☐☐☐

ADDRESS:

CITY: ST: ZIP:

PHONE: EMAIL: (OPTIONAL)

ETHNICITY: ☐ AFRICAN AMERICAN ☐ ASIAN or PACIFIC ISLANDER ☐ CAUCASIAN ☐ HISPANIC or LATINO ☐ NATIVE AMERICAN or ALASKAN NATIVE ☐ OTHER

2) PAYMENT INFORMATION

Please select one of the payment options to the left and complete fully

☐ MEDICARE PART B   OR   ☐ MEDICAID

☐ OTHER INSURANCE   ☐ AETNA MEDICARE   ☐ CARESOURCE   ☐ AETNA

☐ CASH $ AMT: ☐☐☐.☐☐

☐ CHECK $ AMT: ☐☐☐.☐☐   ID: ☐☐☐☐
(Please make checks payable to FluStations)

☐ CREDIT CARD $ AMT: ☐☐☐.☐☐   ☐ Visa ☐ MasterCard

NUMBER: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

EXP. DATE: (MM/YY) ☐☐ ☐☐

Cardmember acknowledges receipt of goods and/or services in the amount of the total shown hereon and agrees to perform the obligations set forth by the cardmember's agreement with the issuer.

☐ EMPLOYER $ AMT: ☐☐☐.☐☐

INSURED'S FIRST NAME:

INSURED'S LAST NAME:

INSURED'S DATE OF BIRTH: (MM/DD/YYYY)

PLAN NAME:

Relationship to Insured:

MEMBER ID/#:

GROUP ID/#:

3) AUTHORIZATION

Please answer the following questions and sign and date.

Please answer: Yes No

Yes	No	
☐	☐	1. Has the patient named above had any serious allergic reactions to previous vaccinations?
☐	☐	2. Is the patient named above allergic to any of the following: latex, mercury, thimerosal, gelatin, chicken eggs/feathers, or other vaccine components?
☐	☐	3. Does the patient named above have a history of asthma or any neurological diseases such as Guillian-Barre syndrome?
☐	☐	4. Is the patient named above pregnant?
☐	☐	5. Has the patient named above received any vaccinations in the last 30 days? If so, name: _____
☐	☐	6. I received an information statement for this/these vaccine(s) and have had a chance to ask questions answered to my satisfaction.
☐	☐	7. I understand the benefits and risks associated with this/these vaccine(s) and will consult with my physician if a reaction should occur.
☐	☐	8. The patient named above is healthy, only has a mild illness, or was instructed by his/her physician to receive this vaccine.

<u>Consent for Use of Protected Health Information & Claims Assignment:</u> I hereby consent to the use and disclosure of my personal health information for the purpose of health care operations, along with the assignment of all payment from the insurer listed above to VaxCare associated with the services contemplated herein.

<u>Vaccine Authorization:</u> My signature on this form indicates that I have requested that the vaccine indicated below be administered to me by a FluStation or VaxCare representative. I relieve the FluStation partner or VaxCare and the administering Nurse and personnel of any liability for any reactions that should occur. In the case of occupational exposure, VaxCare has patient permission for blood testing for patient and employee safety alike. I have read or have had explained to me the information on this form. <u>If consenting for another:</u> I have the legal authority, based on my relationship to the individual indicated above, to consent to this vaccine administration.

SIGNATURE of PATIENT or LEGAL GUARDIAN :

DATE: (MM/DD/YYYY)

4) ADMINISTRATION

OFFICE USE ONLY

Influenza: V04.81   MFR/LOT:

PRES:
☐ MDV 90658	☒ PF 90656	☐ MST 90660	☐ PEDMDV 90657	☐ PEDPF 90655	☐ HD 90662

SITE: ☐ ☐ LD RD OTHER _____
G0008/90471/90473

Nurse/Provider: By my signature, I certify that the patient in question has been given access to current VIS literature (dated 8/10/2010), and that any and all applicable questions were answered prior to vaccine administration.

PROVIDER SIGNATURE:

PROVIDER ID:

DATE: (MM/DD/YYYY)