ABBEVILLE AREA HEALTHCARE CENTER

FLU VACCINE CONSENT AND INSURANCE AUTHORIZATION FORM
PLEASE WRITE NEATLY

PATIENT NAME (As it is on I.D.): _____ SEX: M F DATE OF BIRTH:_____

ADDRESS: _____

CITY/STATE _____ZIP: _____ PHONE #:_____

SOCIAL SECURITY #: _____-_____-_____ INSURANCE CARRIER:_____

SUBSCRIBER NAME:_____ SUBSCRIBER DOB:_____ SS#:_____-_____-_____
PATIENT RELATIONSHIP TO SUBSCRIBER: _____

EMERGENCY CONTACT NAME:_____ PHONE NUMBER:_____

By signing, you agree the information above is correct and give permission for the Physician Practices of Abbeville Area Medical Center to file claims on your behalf.

X_____ Date:_____
Patient Signature

ANSWER THE FOLLOWING:

1. □ YES □ NO Are you allergic to eggs, chicken feathers, or dander?
2. □ YES □ NO Do you currently have an acute illness or infection?
3. □ YES □ NO Have you ever had a severe reaction after a previous influenza vaccination?
4. □ YES □ NO Have you ever had Guillain-Barre' Syndrome?
5. □ YES □ NO Do you have a bleeding disorder?
6. □ YES □ NO Do you have an allergy to Thimerosal?
7. □ YES □ NO Are you allergic to latex?
8. □ YES □ NO Are you taking Coumadin, Theophylline, or Dilantin? (Must have physician approval for vaccine).
9. □ YES □ NO Are you pregnant? (Must have physician approval for vaccine).
10. □ YES □ NO Do you have asthma?
11. □ YES □ NO Have you been around anyone who is immunocompromised?

If you answered YES to any of these questions, you may not be eligible for the influenza vaccine.

POSSIBLE VACCINE SIDE EFFECTS:

1. Local reactions, generally local redness and swelling with or without tenderness.
2. Fever and aches.
3. Life threatening allergic reactions are rare. If they do occur, it is within a few minutes to a few hours after the shot.
4. In 1976, a certain type of influenza (swine flu) vaccine was associated with Guillain-Barre Syndrome (GBS). Since then, flu vaccines have not been clearly linked to GBS. However, if there is a risk of GBS from current flu vaccines, it would be no more that 1 or 2 cases per million people vaccinated. This is much lower than the risk of severe influenza, which can be prevented by vaccination.

I have read the above information and have had an opportunity to ask questions regarding the influenza vaccine. I have received and read the CDC Vaccine Information Statement (VIS).

I CONSENT TO THE FLU VACCINE:

Patient Signature: _____ Date: _____ Time: _____

Mfg #: _____ Lot #: _____ EXP. Date: _____

Site: Right Deltoid or Left Deltoid IM or SQ NURSE SIGNATURE: _____