



Consent for Influenza Vaccine
At the Worksite

First Name (Print Legibly)

Grid for first name input

Address

Text box for address

Last Name

Grid for last name input

City

Text box for city

Date of Birth

Grid for date of birth

Area Code

Grid for area code

Telephone Number

Grid for telephone number

State

Text box for state

Zip Code

Text box for zip code

Health Coverage

Insurance ID#

Group#

Group Health

Grid for insurance ID#

If you are not a Group Health member, please indicate your Health Insurance.

Aetna

Grid for Aetna insurance ID#

Grid for Aetna group number

Regence

Grid for Regence insurance ID#

Grid for Regence group number

Medicare

Other

I have read the 2011-12 Seasonal Influenza Vaccine Information, and have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and request that the vaccine be given to me or the person for whom I am authorized to make this request. I understand that flu vaccine is part of my preventive care benefit - if I owe a cost share, I will be billed for my portion. Please answer the following questions.

The person to receive this immunization:

- 1. Has had an allergic reaction to eating eggs.
2. Has a severe allergy to any vaccine component or has had a reaction after a dose of influenza vaccine
3. Has been paralyzed with Guillain-Barre Syndrome.
4. Is currently ill with a fever.
5. Is or might be pregnant or lactating.
6. Is allergic to latex.
7. Is 65 years of age or older.

If you answer "Yes" to any question, you should discuss the risks and benefits with your primary care physician before receiving a flu shot.

X

Signature of Consent

X

Date of Consent

GROUP HEALTH CLINICIAN TO COMPLETE

Influenza Vaccine Lot Info/Sticker (BELOW)

Date of Administration

Clinician Signature

Date