ADULT SEASONAL INFLUENZA CONSENT (Regular Dose)

Last Name (Please Print) First Name	Date of Birth	M F

Address	City	State MT	Zip

Daytime Phone #	Age

HEALTH INSURANCE INFORMATION

****You will be responsible for any fee not covered by your insurance ****

	Blue Cross Blue Shield	**Insurance ID/Member # - please include all letters and numbers**
	MACo Healthcare Trust	
	Medicare	
	Supplemental	
	Other Insurance:	
	No insurance	Cash Price: Regular-$35.00 65& Older-$57.00 Children 6m-4y $27.00

SCREENING FOR VACCINE ELIBILITY

If "Yes" to any question 1-4, we cannot vaccinate. Please contact your doctor to discuss options	YES	NO
1. Serious allergy to eggs?		
2. Ever had a serious reaction to a previous dose of flu vaccine that required medical care?		
3. Ever had Guillain-Barre Syndrome (a type of severe muscle weakness) after receiving flu vaccine?		
4. Allergy to thimersol or latex?		

CONSENT FOR VACCINATION

By signing below I consent to the influenza vaccine. I have read the vaccine information statement for the injectable flu vaccine. I understand the risks and benefits of the vaccine.

I agree to allow this immunization to be entered into the State Immunization Registry.

Signature _____ Printed Name of Signer:_____ Date:_____
(Patient Signature or Parent/Guardian Signature if Patient is a minor)

FOR ADMINISTRATIVE USE ONLY **VIS Date: 08/15/2019**

Vaccine	Date Given	Route	Manufacturer	Lot No.	Expiration date
Influenza		☐ IM Right ☐ IM Left	☐ Sanofi ☐ GSK ☐ Novartis ■ Seqirus	276539	06/14/2021

NDC Code	Initials
70461-320-03	

Nurse's Note: