St. Landry
Family Healthcare

Elliot Myers, APRN, FNP-C

INFLUENZA CONSENT FORM

Statement of Understanding, Permission, and Agreement

Last Name: ____________________________ First Name: ___________________________ MI: _____

Date of Birth: _________________

STATEMENT OF UNDERSTANDING: I have read and understand the information provided to me about receiving vaccines for influenza, and I have had the opportunity to ask questions. I understand that being allergic to eggs may be a reason for not receiving the influenza vaccine. I affirm to the best of my knowledge that the following questions have been answered truthfully:

	Check yes or no
1. Are you allergic to eggs?	☐ Yes ☐ No
2. Have you had a serious allergic reaction to the influenza vaccine?	☐ Yes ☐ No
3. Do you have a history of Guillain-Barre’ Syndrome?	☐ Yes ☐ No
4. Do you have a fever with a temperature of above 100?	☐ Yes ☐ No
5. Do you have asthma?	☐ Yes ☐ No
6. Do you have a latex allergy?	☐ Yes ☐ No

STATEMENT OF PERMISSION AND ASSIGNMENT: I voluntarily give my permission to receive the influenza vaccine. I understand that payment for this service may be made in accordance with the provisions of Title XVIII of the Social Security Act (Medicare), and/or Title XIX of the Social Security Act (Medicaid); and/or private insurance or other third-party payor. I hereby authorize the provider of service to release information necessary for the processing of any claim for payment made on my behalf, and I authorize payment to the provider for such claim. I understand that I am responsible for any cost incurred that is not covered by a third-party payor.

____ _________________________
Signature Date

For Provider Use Only:

Influenza Vaccine Mfgr: Sanofi Pasteur Lot #: ________________________ Expires: ________________

Injection Site: ☐ Left deltoid ☐ Right deltoid

Administered by: ____ Date: __________________

☐ State Supplied

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