

## McLaren Print System Order

Order No: 56858 Reprint Previous Order No: 5506  
 Order Date: 2020-09-16  
 User: Timery Smith  
 Phone: 15179753770

Ship Location: MGL Holt Family Medicine  
 2450 Delhi Commerce Dr Suite 16  
 Holt, Michigan 48842

### Forms

Quantity: 100  
 Paragon Dept No: 67600  
 Dept Name: MGL Holt Family Medicine  
 Company Number: 810

Order Total Price: 23.40

Item Number: MM-474  
 Item Description: Influenza Consent Form  
 Revision Date: 6/2020  
 Print: 1 sided black and white  
 Paper: 2 Part (White, Yellow)  
 Size: 8.5 x 11  
 Fold:  
 Finish:  
 Drill: None  
 Misc Info: This form must be ordered with DCH-0457



### INFLUENZA CONSENT & ADMINISTRATION FORM

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Sex:  Male  Female  
 Address \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Telephone (\_\_\_\_) \_\_\_\_\_ Primary Care Provider (PCP) \_\_\_\_\_

Not all individuals receiving the influenza vaccine can be safely vaccinated. Please complete the following questions to evaluate any contraindications to the influenza vaccine.

1. Do you have any severe, life-threatening allergies?  Yes  No  
If yes, describe the allergy: \_\_\_\_\_
2. Have you ever had a severe reaction to a previous influenza vaccine or any of its components?  Yes  No  
If yes, describe the reaction: \_\_\_\_\_
3. Do you have a fever or active illness?  Yes  No
4. Do you have a past history of Guillain-Barre Syndrome?  Yes  No
5. Do you have a history of asthma or wheezing? (for intranasal administration only)  Yes  No

As with any medication, there are risks and possible side effects/reactions. Side effects/reactions of influenza vaccine are generally mild, usually occur soon after vaccination and last for 1-2 days. In rare cases, side effects/reactions of influenza vaccine may include anaphylaxis and even death. If you think you are having a severe reaction or other emergency, STOP, SEEK HELP, CALL 911/911/911.

I have received and reviewed the Influenza Vaccine Information Statement (ISVIS) (2019) and have had the opportunity to ask questions. I have been advised to remain under observation for at least 15 minutes following vaccination. I understand the benefits and risks of the influenza vaccine as described. I hereby agree to release and hold McLaren Medical Group, its employees, agents and representatives, harmless from further responsibility with regard to my receiving the vaccine. I consent the influenza vaccine to be given to me or to the person named for whom I am authorized to sign.

Signature of Patient or Authorized Representative (include relationship) \_\_\_\_\_ Date \_\_\_\_\_  
If Under 18, Signature of Parent or Legal Guardian Required (include relationship)

clinic staff. For any YES responses and an active patient, review with the provider. Otherwise, return patient back to their PCP. I have reviewed and authorize vaccine administration. Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

McLaren Medical Group was unable to administer your influenza vaccine today due to a contraindication. Please take a copy of this form to your Primary Care Provider.

**FOR MEDICARE PATIENTS ONLY**

I request that this provider be paid authorized Medicare benefits, on my behalf for any services furnished to me. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits for related services. I understand that I am responsible for the charges if my Medicare coverage is not appropriate. Medicare Number: \_\_\_\_\_

\_\_\_\_\_  
 Patient Signature  Payment to Patient  Payment to Provider

Size of Injection:  Right Deltoid  Left Deltoid  Right Anterolateral Thigh  Left Anterolateral Thigh  Intranasal

Last Number: \_\_\_\_\_ Medication: \_\_\_\_\_ Expense Paid: \_\_\_\_\_

Administered by: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_