PUBLIC HEALTH ADULT ONLY INFLUENZA VACCINE
2022-23 Immunization Screening and Consent

Revised 8.9.2022

Last name ____________________First name __________________Middle name_________________

Address: ______________________City:________________________State___________Zip__________

Date of Birth: _______________ Age: _________years Circle → Male or Female

Phone: ________________________________ Other phone: _________________

I agree to the following:

1. Medicare B clients: I agree to have my insurance billed. Medicare B payment will be considered payment in full.
2. Wellmark BCBS and Aetna clients: I agree to have my insurance billed. If the insurance does not pay the whole amount, I agree to pay the difference.
3. We do not bill Medicare HMO's or Medicaid HMO's; you must pay the private pay cost and work with your insurance company for reimbursement.
4. I have read or seen a copy of the appropriate Vaccine Information Sheet or had the information explained to me.
5. I understand the risks of the vaccination and request that the flu shot is given to me.
6. I accept responsibility for seeking medical attention for any problems with this vaccine.
7. The person getting the shot has not had a severe allergic reaction after a previous dose of influenza vaccine and/or has no severe life threatening allergies.
8. The person being immunized doesn't have a fever, isn't moderately or severely ill, and doesn't have COVID symptoms.
9. The person getting the shot has never had Guillain-Barre Syndrome.
10. In addition, the person getting intranasal Flumist is not pregnant or possibly pregnant, does not have a weakened immune system or does not care for an immunocompromised person, has not taken influenza antiviral medication in the previous 48 hours, and does not have underlying health conditions.

SIGNATURE ____**DATE**________________________

***Medicare # ____________________** **Medicare Part B? Circle → Yes or No**

You must have Part B in order for "regular" Medicare to pay for the flu shot.

Is the Medicare plan an HMO? *If so, we do not bill HMO's, give client a receipt to bill the HMO.*

Staple a copy of Wellmark card or BCBS/Aetna Member Id#____________________________

Group # ______________ **Insured member name**_______________ **Member's Date of Birth**________

Regular Shot (18-64); High Dose (65 and older); Fluad (65 and older); Flublok (18 years and older) or FluMist (18-49)

***Private Pay $**__________ **(circle→) Cash or Check#** _________ **Receipt given by** ______ (initials)*

Or bill to: ____

FOR OFFICE USE BELOW******************* Please review or give current VIS sheet to patient.***

Immunization Date	Brand & Lot # (ok to use sticker)	Dosage, Route & Site *(circle)*		Vaccinator Signature	IRIS entry date and initials
		0.5 ml IM L deltoid R deltoid	0.2 ml IN		