PUBLIC HEALTH ADULT ONLY INFLUENZA VACCINE
2021-22 Immunization Screening and Consent

Revised 8.25.2021

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 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, Medicaid HMO's or private non-BCBS insurance; 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, or has any severe life threatening allergies.
8. The person getting 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 Member Id#_____

Group # _____ **BCBS Insured member name**_____ **Member's Date of Birth**_____

Regular Shot (18-64) or High Dose (65 and older) or 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
		0.5 ml IM **L deltoid** **R deltoid**	**0.2 ml IN**	

Entered in IRIS by: _____ Date: _____