

**Influenza Vaccine ADULT Consent Form
2026-2027 Screening and Consent**



Rev. 9/05/25

Last name _____ First name _____ Middle name _____

Address: _____ City: _____ State _____ Zip _____

Date of Birth: _____ Age: _____ years Circle → Male or Female

Phone: _____ Other phone: _____ **Agricultural Worker → Yes or No**

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 (19-64); High Dose (65 and older); or FluMist (19-49)

Private Pay \$ _____ **(circle→) Cash or Check#** _____ **Receipt given by** _____ **(initials)**

Or bill to: _____ **VFA Eligible:** _____ **- include copy of insurance card**

Vaccines for Adults Program (VFA) provides vaccines to adults 19 years of age and older who qualify. Eligible adults are those who are:

- Uninsured – Does not have insurance
- Underinsured – Vaccines are not covered by insurance, cover only selected, caps prevention services, or does not provide first-dollar coverage for vaccines

For those who are underinsured, please bring your insurance card.

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

Immunization Date	Brand & Lot# Or use sticker	Dosage, Route, & Site		Vaccinator Signature	IRIS entry date and initials
		0.5 ml IM Deltoid Left or Right	0.2 ml IN		