



Saint Alphonsus

A Member of Trinity Health

Influenza Vaccine Administration Consent and Billing Form

First Name _____		Last Name _____		MI _____	Date of Birth _____	Phone Number _____
Parent/Guardian Name _____				Ethnicity _____	☐ Male or ☐ Female	
Home Address _____			City _____		Zip Code _____	
Insurance Plan _____		Insured Number _____		Group Number _____		
Is the person to be vaccinated sick today?						☐ Yes ☐ No
Is the person receiving vaccine today allergic to an ingredient of the vaccine?						☐ Yes ☐ No
Has the person to be vaccinated ever had a reaction to influenza vaccine in the past?						☐ Yes ☐ No
Has the person to be vaccinated today had Guillain-Barré Syndrome?						☐ Yes ☐ No
Has the person to be vaccinated ever felt dizzy or faint before, during, or after a shot?						☐ Yes ☐ No
Is the person to be vaccinated anxious about getting a shot today?						☐ Yes ☐ No

I hereby attest to the following: (1) I am of legal age and authorized to execute this consent form on behalf of myself or the individual receiving the vaccine(s); (2) I voluntarily consent to the administration of the vaccine(s) by an individual legally authorized to administer vaccines; (3) the information I have provided in this form is correct and I, or the person for whom I am consenting, meet eligibility criteria for the vaccine(s); (4) I have been offered and/or provided a copy of the company's Notice of Privacy Practices in compliance with the Health Insurance Portability and Accountability Act (HIPAA); (5) I have received, read and/or had explained to me the Vaccine Information Statement(s) (VIS) to be administered; (6) I understand the risks and benefits of the vaccine(s); and (7) I have had the opportunity to ask questions and they have been answered to my satisfaction. I acknowledge the vaccinated will be advised to wait for 15 minutes for observation and may decline at their own risk and against medical advice. If an adverse event occurs, I consent to the administration of emergency measures deemed necessary. I release Saint Alphonsus from all liability, including acts of omission or commission, resulting from, in connection with, or in any way related to the administration of the vaccine(s). I authorize Saint Alphonsus to release any medical records necessary to process this claim for reimbursement. I acknowledge this vaccination may be subject to reporting to my state's immunization registry; I understand that I may be able to opt out of such reporting by following the requirements set by my state. By signing below, I acknowledge and agree with the above statements and give my consent for vaccination.

Signature X _____ Date X _____
Signature of person to receive vaccine or person authorized to make the request (parent/legal guardian)

For Clinic/Office Use Only*

Flu brand & lot: _____ Inject Site: _____ Nurse's Signature: _____