1570213582

IMMUNIZATION CONSENT FORM

FLU BUSTERS
CARE DYNAMIX

First Name | MI | Last Name

Number & Street Address

City | State | Zip Code

Phone Number | Birth Date | Age | ☐ Male ☐ Female

INFLUENZA VACCINE

The flu vaccine does not protect against all strains of the influenza virus. The ability of flu vaccine to protect a person depends on the age and health status of the person getting the vaccine, and the similarity or "match" between the virus strains in the vaccine and those in circulation. **The flu vaccine, which is made from dead influenza viruses, cannot give you the flu.** If you question whether you should receive the flu vaccine, you should contact your personal physician. A small percentage of those vaccinated may experience minor side effects, such as soreness around the vaccination site for up to two days, headache or low-grade fever. Immediate, presumably allergic, reactions such as hives, angioedema, allergic asthma or anaphylaxis occur rarely after influenza vaccination. These reactions probably result from hypersensitivity to some vaccine component – the majority of reactions are most likely related to residual egg protein. Individuals with anaphylactic hypersentsitvty to eggs should not be given an influenza vaccine. Guillian-Barre Syndrome ("GBS") was noted to be a rare sequel of influenza vaccination during the 1976 "swine" influenza immunization program. Recent information does not indicate a clear risk of GBS in recipients of the flu vaccine compared to non-vaccines. (Additional information relating to adverse reactions and side effects will be provided upon request.) Please contact your personal physician in the event of a reaction. **Because of the potential for allergic reaction you are asked to remain in the immediate area for observation purposes for the next 20 minutes after receiving the vaccine. You must answer the following questions prior to receiving the vaccine (Check yes or no).**

1. Are you allergic to chicken eggs, mercury or sensitive to sulfites (found in cheese and wine)?	☐ Yes	☐ No	4. Are you pregnant or currently nursing a baby?	☐ Yes	☐ No
2. Do you currently have an acute infection or fever?	☐ Yes	☐ No	5. Do you have a severe blood clotting disorder?	☐ Yes	☐ No
3. Have you ever had a severe reaction to a flu shot?	☐ Yes	☐ No	6. Have you received any other vaccine within the past 14 days?	☐ Yes	☐ No

CONTACT YOUR PHYSICIAN AND/OR HEALTHCARE PROVIDER BEFORE RECEIVING THIS VACCINE IF YOU CHECKED YES ON ANY OF THE ABOVE QUESTIONS.

PNEUMONIA VACCINE

As with any medication, there are risks and possible side effects/reactions. Side effects of the pneumonia vaccine are generally mild in adults and occur within 6 to 12 hours after vaccination and can persist for one or two days. These reactions consist of soreness of the injection site, fever, chills, muscular aches, and, in rare cases, death. Immediate, presumably allergic, reactions such as hives, angioedema, allergic asthma or anaphylaxis occur rarely after the pneumonia vaccine. These reactions probably result from hypersensitivity to some vaccine component. If you should have a reaction, you should contact your physician. **Because of the potential for allergic reactions, you are asked to remain in the immediate area for observation purposes for the next 20 minutes after receiving the vaccine. You must answer the following questions prior to receiving the vaccine (Check yes or no).**

1. Have you ever had a Pneumonia shot before? If yes, when? _____	☐ Yes	☐ No	7. Do you have any hypersensitivity to any component of the vaccine?	☐ Yes	☐ No
2. Are you currently receiving chemotherapy, radiation therapy or immunosuppressive therapy or are you having these therapies within the next two weeks?	☐ Yes	☐ No	8. Are you allergic to neomycin, thimerosal or streptomycin?	☐ Yes	☐ No
3. Are you pregnant?	☐ Yes	☐ No	9. Do you have a history of sensitivity to latex	☐ Yes	☐ No
4. Are you currently nursing?	☐ Yes	☐ No	10. Have you had Pneumonia within the past year?	☐ Yes	☐ No
5. Have you ever had an adverse reaction to another vaccine? If yes, what? _____	☐ Yes	☐ No	11. Are you currently receiving any blood thinners such as coumadin or heparin?	☐ Yes	☐ No
6. Do you have a past history of Guillain-Barre syndrome?	☐ Yes	☐ No	12. Do you currently have a fever or respiratory illness or any other type of infection?	☐ Yes	☐ No

CONTACT YOUR PHYSICIAN AND /OR HEALTHCARE PROVIDER BEFORE RECEIVING THIS VACCINE IF YOU CHECKED YES ON ANY OF THE ABOVE QUESTIONS.

WAIVER AND RELEASE

I hereby release and forever discharge and hold harmless Flu Busters, and its directors, officers, employees, agents and assigns, any retail site, grocery store, pharmacy, corporation, physician and/or medical director and their respective directors, officers, employees, agents and assigns (hereinafter, collectively referred to as "Releasees") from any and all liability, claims, demands, and causes of action, of whatever kind or nature, either in law or equity, which may hereafter arise from my receipt of the flu vaccine. I understand and acknowledge that this Consent and Release discharges Releasees from any liability or claim that may arise as a result of my receipt of the flu vaccine, with respect to any bodily injury or other injury, including any mental injury, illness, death, or property damage that may result. I understand that Releasees do not assume any responsibility or obligation to provide financial assistance or other assistance, including, but not limited to medical, health, or disability insurance, in the event of injury, illness, death or property damage, unless otherwise expressly provided. I expressly understand and agree that this Consent and Release is intended to be as broad and inclusive as permitted by law, and this Consent and Release shall be governed by and interpreted in accordance with the laws of the State of Georgia. I agree that in the event that any clause or provision of this Release shall be held to be invalid by any court of competent jurisdiction, the invalidity of such clause or provision shall not affect the remaining provisions of this Consent and Release.

PAYMENT INFORMATION

Any returned checks or denied credit card transactions are subject to the maximum allowed fee. Medicare MUST be your primary provider to be accepted or it will be denied and you will owe the full shot amount.

Cash Amount $ ____.____

Check # _____ Check Amount $ ____.____

For your convenience, if your check is dishonored or returned for any reason, we will electronically debit your account for the amount of the check plus a processing fee of $30.

Credit Card ☐ Visa ☐ Master Card Amount $ ____.____ Exp Date __/__/__

Card # _____ **Security Code** ____

Signature _____

☐ Check here if the name on your card or your credit card billing address is different from above and write the alternate name and/or billing address on the other side of this form.

Medicare # (ALL letters and numbers, must be primary provider) ____-____-____

Letter(s) Prefix ____ **Letter(s) Suffix** ____

Patient's Name First Name | MI | Last Name

Enter information exactly as it appears on Medicare Card. Participants with Medicare HMO must pay for services. I attest Medicare Part B is my PRIMARY medical coverage or I will be charged for the vaccination plus the service fee.

Voucher # _____

Nurse Info Only

Influenza Vaccine		Pneumonococcal Vaccine	
☐ Right Deltoid	Nurse Initials _____	☐ Right Deltoid	Nurse Initials _____
☐ Left Deltoid	Nurse Initials _____	☐ Left Deltoid	Nurse Initials _____
Mfr:	Lot #	Mfr:	Lot #

INFORMED CONSENT AND HIPAA PRIVACY INFORMATION

I have read the above Consent and Release and understand its provisions and applicability. I understand the benefits and risks of the flu vaccine as described and request that the vaccine be given to me or the person named above for whom I am the legal guardian. My medical record may be shared with my physician and/or insurer. I understand that Flu Busters will use and disclose my personal health information to treat me, to receive payment for the care it provides me, and for other health care operations, which generally include activities to improve the quality of care. I acknowledge that I have received a copy of Flu Busters' NOTICE OF PRIVACY AND CONFIDENTIAL PRACTICES. I hereby freely and voluntarily, without duress, execute this Consent and Release under the above written terms.

X _____ _____

Signature/Legal Guardian *Date*

_____ X _____

Print Name *Nurse's Signature*

Top = Flu Busters **Bottom = Patient**