SEASONAL INFLUENZA CONSENT FORM

BLACK INK ONLY

Last Name	First Name	MI	Age	Date of Birth ____/ ____/ ____	☐ Male ☐ Female
Street Address (include Apt # if applicable)		City	State	Zip	
Email Address		Phone Number			

HEALTH INSURANCE INFORMATION

☐ Blue Cross Blue Shield (Federal or RI only) _____

☐ UnitedHealthcare ID# _____ Group #_____

☐ Medicare_____

☐ Neighborhood Health Plan _____

☐ Tufts_____

☐ Cigna/Carelink_____

☐ Cigna Healthcare_____

☐ Different or No Insurance – $25

SCREENING FOR FLU VACCINE ELIGIBILITY

1. Any serious allergy to eggs?	Yes	No
2. Ever had a serious reaction to previous dose of flu vaccine that required medical attention?	Yes	No
3. Ever had Guillain-Barre Syndrome (temporary severe muscle weakness) after receiving flu vaccine?	Yes	No

DO NOT WRITE BELOW THIS LINE UNTIL YOU APPEAR FOR YOUR VACCINATION

VACCINE ADMINISTRATION RECORD & WAIVER OF LIABILITY

I have read or have had explained to me the information provided about influenza and influenza vaccine. I have had an opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of influenza vaccine and request that the vaccine be given to me or to the person named above for whom I am authorized to sign. I hereby release *The Wellness Company Inc.* from any and all liability associated with the administration and potential side effects of the vaccine.

This record is evidence and/or documentation that you have received the flu vaccine, and it will be filed with *The Wellness Company Inc*. They will record what vaccine was given, when the vaccine was given, where the vaccine was given, the name of the company that made the vaccine, the vaccine's lot number, and the name and title of the person who gave the vaccine.

Medicare Subscribers Only: I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made to The Wellness Company.
I certify that I have received and/or reviewed a Notice of Privacy Practice provided by *The Wellness Company Inc.*

I give The Wellness Company permission to provide HEALTH SERVICES a copy of my flu consent.

CLIENT SIGNATURE: _____DATE: _____

FOR ADMINISTRATIVE USE ONLY **VIS Date: 8/7/2015**

Vaccine	Route *IM*	Manufacturer	Lot No.	Date VIS Provided	Date Vaccine Given	Signature of Vaccine Administrator
Influenza	*R L*					