PLEASE PRINT AND BRING TWO (2) COMPLETED COPIES OF THIS CONSENT FORM TO THE FLU CLINIC

MAXIM

Branch: Clinic:

INSURANCE CONSENT FORM

Insurance Name:
Insurance ID No.: Group No.:

First Name: Middle Initial:
Last Name:
Address:
City: State: Zip:
Phone: – – Birthdate: M M D D Y Y Y Y Age: Sex: (M/F)

For recipients 18 years of age and under only **Mother's Maiden Name:**

***Precautions and Contraindications:* Please check YES or NO for each question.**

	YES	NO
1. Have you ever had a **severe (life-threatening)** reaction after receiving the influenza vaccine?	☐	☐
2. Are you exhibiting symptoms other than mild coughing, runny nose and/or diarrhea?	☐	☐
3. Have you ever had a **severe (allergic)** reaction to any of the components in the influenza vaccine you will be receiving today? (I.E. eggs, egg proteins, thimerosol, latex, gelatin, arginine, formaldehyde, gentamicin, polymyxin B, neomycin, etc.). Anything other than hives?	☐	☐
4. Do you have a history of Guillain-Barré syndrome (muscle weakness and possibly paralysis) within **6 weeks** of receipt of receiving an influenza vaccine?	☐	☐
CONTACT YOUR PHYSICIAN AND/OR HEALTHCARE PROVIDER BEFORE RECEIVING THIS VACCINE IF YOU CHECKED YES ON ANY OF THE ABOVE QUESTIONS.		
5. Are you pregnant or suspect you are pregnant? If yes, please talk to the nurse before receiving the influenza vaccine.	☐	☐

INFLUENZA VACCINE ADVERSE REACTIONS

Because influenza vaccine contains only non-infectious purified viral proteins, it cannot cause influenza. An occasional case of respiratory disease following immunization represents coincidental illnesses unrelated to influenza immunization.

Mild Problems: Soreness, redness, or swelling where the shot was given. Hoarseness; sore, red or itchy eyes; cough, fever, aches, headache, itching, and fatigue. If these problems occur they usually begin soon after the shot and last 1-2 days.

Severe Problems:

- Life-threatening allergic reactions from vaccines are very rare. If they do occur, it is usually within a few minutes to a few hours after the shot.
- In 1976, a type of inactivated influenza (swine flu) vaccine was associated with Guillain-Barré Syndrome (GBS). Since then, flu vaccines have not been clearly linked to GBS. However, if there is a risk of GBS from current flu vaccines, it would be no more than 1 or 2 cases per million people vaccinated. This is much lower than the risk of severe influenza, which can be prevented by vaccination.

The safety of vaccines is always being monitored. For more information, visit:
www.cdc.gov/vaccinesafety/Vaccine_Monitoring/Index.html and www.cdc.gov/vaccinesafety/Activities/Activities_Index.html

AREA BELOW TO BE COMPLETED BY THE NURSE

Influenza:

Trivalent:	Quadrivalent:	High Dose	T-Free:	T-Free Pediatric:
☐ Fluvirin 90658 ☐ Fluzone 90656	☐ Flulaval 90688	☐ Fluzone 90662	☐ Flucelvax 90661	☐ Fluzone 90685
Lot #_____	Lot #_____	Lot #_____	Lot #_____	Lot #_____

Injection Site:
☐ Left Deltoid ☐ Right Deltoid
☐ Left Thigh (Infant Only)
☐ Right Thigh (Infant Only)

Dose:
☐ 0.5 mL (36 months and older)
☐ 0.25 mL (6-35 months only)

VIS Version Date Issued: _____

Nurse's Signature: _____ **Date of Service:** _____

Corporate Address: 7227 Lee DeForest Drive, Columbia, MD 21046, Phone No. 866-211-0001
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CONSENT FOR SERVICES, MEDICAL RECORDS and HIPAA PRIVACY INFORMATION

I have read the adverse reactions associated with the influenza vaccine. A copy of the vaccine manufacturer's drug information sheet is available on request. I have had the opportunity to ask questions about these immunizations and I have been offered a copy of the Vaccine Information Statement (VIS) for the vaccine(s) being administered. I ask that the immunization(s) be given to me or the person named below for whom I am authorized to make this request. For myself, my heirs, executors, personal representatives and assigns, I hereby release Maxim Health Systems ("Maxim"), any retail site, grocery store, pharmacy, corporation, school, school district, physician and/or medical director and their respective affiliates, subsidiaries, divisions, directors, contractors, agents and employees, from any and all claims arising out of, in connection with or in any way related to my receipt of this or these immunization(s). Maxim and the other aforementioned parties shall not at any time or to any extent whatsoever be liable, responsible, or in any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccines described above. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result. **I agree to remain in the general area for at least 15 minutes after receiving the vaccine.**

I authorize the release of this immunization data/consent form to my physician, my insurer/health plan or a third party designated by my current or future health plan or employer for use in health/disease management and/or incentive benefit programs. If applicable, I further authorize the release of this immunization data/consent form to my educational institution or health care/senior/long term care facility for inclusion in my medical record and continuity of my education and/or treatment/care. I understand if the recipient is not a Covered Entity as defined by the HIPAA Privacy Rule, the information may be redisclosed by the recipient and no longer protected by the privacy regulations. I acknowledge that I received a copy of Maxim's NOTICE OF PRIVACY PRACTICES, which outlines Maxim's practices in the use/disclosure of personal and health information for my treatment, payment for the care/services it provides, and for other health care operations. This authorization shall expire one year from the date I sign it unless I revoke it sooner, in writing, by certified mail, return receipt requested to Maxim Health Systems, LLC, 7227 Lee DeForest Drive, Columbia, Maryland 21046, Attn: Privacy Officer. I understand that revoking this authorization will not have any effect on actions that Maxim took in reliance on this authorization before it received notice of my revocation.

If this Consent Form is signed by the patient's legal guardian, durable power of attorney for healthcare or qualified healthcare surrogate (as defined by state law), I acknowledge that I have full authority to sign on behalf of the patient and maintain all appropriate appointment/governing documentation (e.g.: Durable Power of Attorney for Healthcare/Finances, Letters Testamentary/Administration, Guardianship Orders, etc.).

_____ Initial **I AM A MEMBER OF THE INSURANCE PLAN LISTED ABOVE WHICH IS MY PRIMARY MEDICAL COVERAGE. I ACKNOWLEDGE MY BENEFIT PLAN PROVIDES FULL REIMBURSEMENT TO MAXIM OR I WILL BE RESPONSIBLE FOR PAYMENT.**

X _____ Signature/Legal Guardian

_____ Print Name

Please provide us with your e-mail address if you would like to receive a reminder for your next flu immunization or other upcoming wellness events.
_____. [This information will be kept confidential and only be used for the stated purpose.]

Please provide a copy of this form to your physician and/or healthcare provider for your permanent medical records.