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PATIENT/INSURANCE INFORMATION FORM

CLIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Birth Date: _____ Age: _____ Gender: ☐ Female ☐ Male ☐ Undisclosed

Street Address: _____ City: _____

State: _____ Zip Code: _____ Phone: _____

Are you 18 years or older? ☐ Yes ☐ No, see guarantor information below

Insurance Information: (For onsite clinics, please ensure a copy of the patient's insurance card(s) was collected)

Medicare Fields:

Is the Patient age 65 or older or Medicare Eligible?

☐ Yes ☐ No

Medicare Part A/B ID Number (MBI) **Note:** *MBI is required for all patients age 65 and older, or Medicare eligible. Refer to your Medicare Red, White, and Blue card*

Medical Insurance: Medical Insurance Provider _____ Cardholder ID # _____

Is the patient the primary insurance holder?

☐ Yes ☐ No, see guarantor information below.

If uninsured, you must check the box below to attest that the following information is true and accurate:

☐ I do not have any insurance, including but not limited to Medicare, Medicaid or any other private or government-funded health benefit plan.

In order to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program for Uninsured Patients, please provide either (a) a valid Social Security number, (b) state identification number and state of issuance, OR (c) a driver's license number and the state of issuance.

Social Security Number or State Identification Number & State or Driver's License Number & State

FAMILY/GUARANTOR INFORMATION (Required if client under 18 or client is not guarantor)

Last Name: _____ First Name: _____ Date of Birth: _____

Street Address: _____ City: _____

County: _____ State: _____ Zip Code: _____ Phone: _____

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SEASONAL INFLUENZA VACCINE CONSENT FORM

Last name:_____ **First name:**_____ **DOB:**_____ **Age**_____

1. Have you ever had a severe reaction to the flu vaccination? ☐ Yes ☐ No
2. Have you ever had a severe allergic reaction (anaphylaxis) to eggs, chickens, gelatin or formaldehyde? ☐ Yes ☐ No
   a. FLUCELVAX QUADRIVALENT (regular dose) is egg free, antibiotic free, latex free, preservative free, and pig gelatin free
   b. FLUAD QUADRIVALENT (high dose vaccine for those 65 years of age and older) is **NOT** egg free
3. Do you currently have a fever, active infection, or illness? ☐ Yes ☐ No
4. Do you have a history of Guillain-Barre Syndrome (GBS)? ☐ Yes ☐ No
   a. GBS is characterized by ascending paralysis which is usually self-limited and reversible. The 1976 swine influenza vaccine was associated with an elevated risk of (GBS). If GBS has occurred after receipt of a prior influenza vaccine, the decision to give the flu vaccine should be based on careful consideration of the potential benefits and risks.
5. Are you pregnant or breastfeeding? ☐ Yes ☐ No
   a. The Influenza vaccine can be administered at any time during pregnancy. It is not known whether the flu vaccine is excreted in human milk. **If you have questions or concerns, contact your OB-GYN prior to vaccination.**
6. Are you 65 years old or older? ☐ Yes ☐ No
   a. If you are 65 years or older, the high-dose flu vaccination (FLUAD QUADRIVALENT) which offers more protection against the flu, may be available. If you would like to receive the high-dose flu vaccine, discuss this option with the CNS staff

CONSENT: I have read or have had the information regarding the influenza (Flu) vaccination explained to me. I have had an opportunity to discuss the benefits/risks of the influenza vaccination with a healthcare provider. Possible adverse reactions to influenza vaccine have been explained to me, with good understanding of the same. These include but are not limited to: soreness at the site, low-grade fever, malaise and myalgia. These symptoms may occur 6-12 hours after vaccination and may persist for 1-2 days. I understand that immediate, presumably allergic reactions, such as hives, angioedema or various respiratory problems are likely the result of hypersensitivity to the influenza vaccination. All questions regarding the influenza vaccination were answered to my satisfaction. I understand the benefits and risks of influenza vaccine and consent/request to receive the influenza vaccination, administered by the CNS medical staff.

I agree to hold CNS harmless for any adverse effects the vaccination may cause me. I agree to see my primary care physician for any influenza vaccination adverse effects. I understand that CNS does not offer evaluation or treatment for adverse effects related to the influenza vaccination.

X_____ Date: _____ Witness: _____

Signature of person receiving vaccine

FOR ADMINISTRATIVE USE ONLY

Vaccine	Route and Site	Date Dose Administered	Vaccine Manufacturer	Lot Number, Expiration Date, VIS Date	Name and Title of Vaccine Administrator
☐ Flucelvax (regular dose) ☐ Fluad (high dose)	IM ☐ R Deltoid ☐ L Deltoid	/ /		VIS: 8/6/21	

☐ **Influenza vaccination was NOT administered today due to:** _____