Franciscan Healthcare

INFLUENZA VACCINATION
ASSESSMENT AND CONSENT FORM

Patient's Name:_____ Birth Date:_____

Doctor:_____

Have you received an influenza vaccination in the past 30 days? Yes_____ No_____

(If yes, vaccination is not indicated. If No, continue assessment for contraindications.)

Have you ever had a severe (anaphylactic) reaction to a flu shot? Yes_____ No_____

Are you allergic to eggs or egg products, thimerosal-containing products (eye contact lens solution) or mercury containing products? Yes_____ No_____

Do you currently have an illness with fever? Yes_____ No_____

Consent for Influenza injection:

The information on the flu vaccine statement was available to me. I have had a chance to ask questions and these have been answered to my satisfaction. I understand the benefits and risks of the vaccine and asked that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I accept responsibility for seeking medical attention for any problems with this vaccination. Franciscan Healthcare will bill your insurance carrier. I authorize direct payment of benefits to Franciscan Healthcare. I will be responsible for the entire unreimbursed balance of the claim to the extent permitted by law.

Signature of Patient/Parent/Guardian: _____ Date:_____

FOR NURSE USE ONLY:

Influenza Administered

Influenza Vaccine
Site: RD/LD
RVL/LVL

Administered By:_____

Date Given:_____

Manufacturer:

09/14/20 hlk

430 N Monitor Street | West Point, NE 68788-1595 | P: 402.372.2404 | F: 402.372.2360 | franhealth.org

Sponsored by the Franciscan Sisters of Christian Charity