MHI Health
Mile Hi Immunizations & Healthcare Services

2011 INFLUENZA CONSENT FORM – Medicare

MEDICARE ID# (Include ALL letters & numbers)

NAME LAST (one character per box) NAME FIRST MIDDLE INITIAL

STREET ADDRESS

CITY STATE ZIP

SEX DATE OF BIRTH AGE PHONE

M / F M M / D D / Y Y Y Y

Precautions & Contraindications: Please Shade-In "Yes" or "No" for each question.

1. Have you ever had a flu shot before?..... YES _____ NO _____
2. Are you currently receiving chemotherapy, radiation therapy or immunosuppressive therapy?..... YES _____ NO _____
3. Do you have any known sensitivities to any components of Influenza virus vaccine? ..... YES _____ NO _____
4. Have you ever had an adverse reaction to another vaccine? ..... YES _____ NO _____
   Please list the adverse reaction_____
5. Do you have a past history of Guillain-Barre syndrome? ..... YES _____ NO _____
6. Do you have any history of hypersensitivity to chicken eggs or egg protein, chicken or feathers? ..... YES _____ NO _____
7. Do you have any hypersensitivity to any component of the vaccine, including thimerosal? ..... YES _____ NO _____
8. Do you have a history of sensitivity to latex? (refers to gloves and rubber stopper) ..... YES _____ NO _____
9. Do you currently have a fever or respiratory illness or any other type of infection? ..... YES _____ NO _____

BASED UPON YOUR RESPONSES TO THE ABOVE QUESTIONS, THE NURSE MAY REFER YOU TO YOUR PHYSICIAN FOR YOUR INJECTION.

I understand the adverse reactions associated with the Pneumonia vaccine and I am aware that a copy of the vaccine manufacturer's drug information sheet is available at the CDC website. Furthermore, I have also had an opportunity to ask questions about this immunization. I believe that the benefits outweigh the risks and I assume full responsibility for any reactions that may result. My medical record may be shared with my physician/insurance. I waive and release any and all claims I, or anyone claiming by or through me, now have or may hereafter acquire against Mile High Health Solutions and the clinic site sponsor and their respective parent, subsidiaries, and affiliates, and each of their directors, officers, employees, and agents for any and all damages or injuries arising out of or related to the receipt of the pneumonia shot, including, without limitation, if I, the person named below for whom I am authorized to make this request, contract Pneumonia, other respiratory diseases, or suffer any other damages or adverse reactions, including death, following administration of this pneumonia shot. I am requesting that the immunization be given to me or the person named below for whom I am the legal guardian. ****MEDICARE B ONLY: I am not a member of an HMO (Health Maintenance Organization) i.e., CIGNA, PacifiCare, Intergroup, etc. Medicare B is my PRIMARY Medical Coverage or I will be responsible for the charges.**

X_____ (Signature/Legal Guardian) Date: _____

For OBSERVATION: Please remain on the premises for 10 minutes following vaccination. If you leave the area, you are doing so against medical advice. Your safety is our primary concern.

THIS SECTION TO BE COMPLETED BY NURSE

SITE: ☐LD / ☐RD NURSE'S INITIALS: _____

LOT #: CLINIC DATE: / / 2 0 1 1