

Branch: Clinic:

IMMUNIZATION CONSENT FORM

First Name: Middle Initial:

Last Name:

Address:

City: State: Zip:

Phone: - - Birthdate: Age: Sex: (M/F)

Employee ID:

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?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you exhibiting symptoms other than mild coughing, runny nose and/or diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>
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, thimerosal, latex, gelatin, arginine, formaldehyde, gentamicin, polymyxin B, neomycin, etc.). Anything other than hives?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>

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. YES NO

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: <input type="checkbox"/> Fluvirin Q2037 <input type="checkbox"/> Fluzone Q2038 Lot # _____	Quadrivalent: <input type="checkbox"/> Flulaval Q2036 Lot # _____	High Dose <input type="checkbox"/> Fluzone 90662 Lot # _____	T-Free: <input type="checkbox"/> Flucelvac 90661 Lot # _____	T-Free Pediatric: <input type="checkbox"/> Fluzone 90685 Lot # _____	Injection Site: <input type="checkbox"/> Left Deltoid <input type="checkbox"/> Right Deltoid <input type="checkbox"/> Left Thigh (Infant Only) <input type="checkbox"/> Right Thigh (Infant Only) Dose: <input type="checkbox"/> 0.5 mL (36 months and older) <input type="checkbox"/> 0.25 mL (6-35 months only)
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VIS Version Date Issued: _____

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

PAYMENT INFORMATION

	Amount Paid
<input type="checkbox"/> 90658 (or vaccine specific Q code above) Flu Injection G0008 Dx Z23	\$ _____
<input type="checkbox"/> 90655 Preservative Free, 6-35 Month Flu Injection G0008 Dx Z23	\$ _____
<input type="checkbox"/> 90657 Multidose Vial, 6-35 Month Flu injection G0008 Dx Z23	\$ _____

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 Healthcare Services, Inc. ("Maxim") and its subsidiaries, affiliates and assigns, 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.).

X _____
 Signature/Legal Guardian Print Name

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