EveryStep Community Health

VACCINATION CONSENT & INSURANCE FORM – 2021-2022

CLINIC LOCATION:_____ **DATE:**_____

Personal information

Last Name:_____ **First Name:**_____ **Middle Initial:**___

Address:_____

City: _____ **State:** ___ **Zip:** _____

Date of Birth:___/___/____ **Age:**___ **Sex:** ___ **M** ___ **F** **Phone:** (___)___-____

Please answer each of the following questions:

1.	Is this your FIRST flu vaccination ever?	☐ Yes	☐ No
2.	Are you allergic to eggs, gentamicin, gelatin, arginine or a previous vaccination?	☐ Yes	☐ No
3.	Have you had Guillain-Barre Syndrome, a severe paralytic illness?	☐ Yes	☐ No
4.	Do you feel moderately or severely ill and/or are you running a fever today?	☐ Yes	☐ No
5.	Do you have COVID-19 symptoms such as cough, breathing difficulty, new loss of taste/smell?	☐ Yes	☐ No

Ins. information

***COPIES OF INSURANCE CARDS** (front and back preferred)

Insurance Company Name:_____

Member ID #:_____ **Group:**_____

***If Insurance Policy Holder is other than self:** **Relationship:** ___ Spouse ___ Parent

Name:_____ **Policyholder DOB:**___/___/____

I acknowledge that a copy of EveryStep's Notice of Privacy Practices is available to me. I understand that this document provides an explanation of the way in which my health information may be used or disclosed by EveryStep and of my rights with respect to my health information. The current VIS for the Flu Injection or Flu Mist immunizations has been provided by EveryStep. I have had an opportunity to ask questions and have received answers to my satisfaction. I understand the benefits and risks of the vaccination and expressly understand if I experience any side effects, it is my responsibility to follow up with my physician at my expense. I hereby release EveryStep, its officers, employees, and agents from any and all liability that might arise from vaccination on behalf of me, my heirs, and personal representatives. ***I understand I am financially responsible to EveryStep for any charges denied by my insurance company or copayment amounts due after the insurance company has paid.*** *Parent/Guardian: (Ages 6 months-17 years) I attest that I am the child's parent, authorized representative, or legal guardian and can provide effective consent for this immunization.*

☆ **Signature:**_____ **Date:**_____

NURSE ONLY

☐**Cash** ☐**Check #** ☐**Voucher** ☐ **Corp Bill** ☐ **Insurance Bill** ☐**Medicare/Advantage Plan**

☐**Dose: 0.25 ml (6-35months Afluria)** **MFG/Vaccine:**

☐**Dose: 0.5 ml (3 yrs+ Afluria or 2 yrs+ Flucelvax)** **Lot#:**

SITE: IM ☐**RD** ☐**LD** ☐**RVL** ☐**LVL** **Exp Date:**

Given by: _____ **Date:** _____