Influenza "Flu" Vaccination Consent Form

Please PRINT legibly!

PATIENT'S NAME: last:_____ first:_____

Date of Birth: _____/___/____ (Must be 18 years of age to participate) **Gender: Male or Female**

Home Address:_____ City/State:_____ Zip:_____

Employer:_____ □ Employee □ Dependent

Best Contact Phone Number: _____

Please answer the following questions:

1. Is this the first time you've received a flu vaccine? ____Yes ____No
2. Have you ever had a life-threatening allergic reaction to a flu vaccine? ____Yes ____No
3. Have you ever had a severe allergic to any egg? ____Yes ____No
4. Has a doctor ever told you that you had Guillain-Barre Syndrome (GBS) – a paralyzing nerve disease? ____Yes ____No

- I have received the CDC's current Vaccine Information Statement (8.6.21) about the flu vaccine.
- I hereby authorize and consent to receive the Influenza "Flu" Vaccination. I understand that it is my responsibility to contact my personal physician or on-site nurse with any questions I might have regarding this vaccination. I have read and understand the information provided to me, and I have answered all of the questions honestly. I hereby release and hold harmless Ochsner Health System, its staff, and any other persons involved, including independent physicians from any liability or claim arising from any injury or complications that may result from the administration of this vaccine.
- I acknowledge that I have been provided with a copy of the Health Insurance Portability and Accountability Act Notice of Privacy Practices.
- I understand my employer will be informed that I have received the annual flu vaccine.
- I acknowledge that my flu vaccine will only be paid for through my **primary** insurance coverage. If for any reason, this insurance payment is denied, I accept full financial responsibility for the cost ($26) of the vaccine and its administration.

Patient's Signature: _____ Date: _____

********* For Ochsner Corporate Wellness Use Only *********

Cash: __ Check:___ Bill Co: ____ (arrangements made in advance)

Bill Insurance: □Humana, □BCBS of LA (A front-and-back copy of the card must be attached)
(CANNOT ACCEPT: Office of Group Benefits, Federal Employee plans, Medicare, Medicaid, OR retiree plans)

Ochsner Representative: _____ Date: _____

0.5 cc IM split virus vaccine given in (check one) □ left deltoid □ right deltoid
Date: _____/_____/2022, Time: _____AM / PM, Lot #/Exp.:_____

Administered by: _____

□ 1st time recipients of vaccine are asked to wait 5 minutes for observation □ Patient refused wait for observation
Nurse's Notes: _____