2014-15 Influenza Vaccine & Adult Adacel (Tdap) Vaccine Consent Form

Date:	**Birth Date:**	**Age:**	**Gender:** Male / Female
Patient Name:		**Phone Number:**	

The following questions will help us determine which vaccine may be given to the patient. If a question is not clear, please ask a member of Premier Pediatrics to clarify.

	Influenza Eligibility Screen	**Yes**	**No**	**Unsure**
1	Is the person receiving the vaccine ill today?			
2	Has the person receiving the vaccine ever had an allergic reaction to medications, vaccines, food, or eggs?			
3	Does the person receiving the vaccine have a history of wheezing or asthma?			
4	Does the person receiving the vaccine have a compromised immune system (example: cancer, leukemia, HIV, complement deficiency, asplenia) or live with someone who does?			
5	Does the person receiving the vaccine have a history of seizures or brain / nervous system problems?			
6	Has the person receiving the vaccine taken Aspirin or any other medication containing Aspirin in the last month?			
7	Is the person receiving the vaccine pregnant?			

Authorizations – Please initial each section and sign.

1. _____ I voluntarily submit to an authorize Premier Pediatrics to administer the influenza and/or Adacel Vaccine. I understand that if this is not a covered service under my insurance, that I will be responsible for the cost.
   Influenza: $20.00 Flu Mist: $25.00 Adacel: $35.00

2._____ I have been offered a copy of the practice Health Insurance Portability and Accountability Act (HIPAA) policy.

3._____ I have had explained to me the information contained in the Vaccine Information Sheet for the vaccine. I have had the chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and request that the vaccine indicated be given to me.

4._____ I understand that my insurance coverage may not provide payment for all charges for treatment. I am aware that I will be responsible for any copay, coinsurance, deductible, or service not covered by my insurance policy. If I do not have insurance coverage, I understand that payment must be made at the time of service.

5._____ By signing below, I certify the accuracy of the above information and authorize the release of any medical information necessary to process the claim. I consent to treatment and hereby assign benefits payable to this facility.

Signature: _____ **Date:** _____

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Vaccine	**VIS Given**	**VIS Form & Date**	**Site**	**Man. / Lot**	**Admin By**	**Billed**
Flu 0.5 mL Tri Quad	Yes No	Inactivated Influenza (07/26/2013)	IM – L R Arm	Sanofi Pasteur		
FluMist	Yes No	Live Influenza (07/26/2013)	Intranasal	GSK	**Temp:**	
Adacel	Yes No	Tdap Vaccine (05/09/2013)	IM – L R Arm	Sanofi Pasteur		