

Office Use Only

Clerk Initials: _____

Clinic Location: _____

INFLUENZA VACCINATION CONSENT 2008-2009

University of Rochester, Center for Nursing Entrepreneurship



601 Elmwood Ave., Box SON
Rochester, NY 14642
585-275-0636
www.rochesterflu.org

Cicero Professional Office Building
6221 Route 31, Cicero NY 13039
315-698-8858
www.syracuseflu.org

SANOFI VACCINE ONLY

**CHILD:
18 YEARS OF AGE
OR LESS**

Last Name _____ First Name _____ Middle Name _____

Street Address _____ City _____ State _____ Zip _____

Phone # _____ DOB _____ Age _____ Doctors name _____

Mother's Maiden Name _____ Male _____ Female _____

WRITE THE NUMBERS & LETTERS FROM YOUR INSURANCE CARD — KEEP INSURANCE CARDS OUT

◆ **EXCELLUS #** _____ - _____ (2 Digit Suffix is on back of card in front of name)

Subscriber Name: _____ Your Relationship to Subscriber: _____

◆ **PREFERRED CARE #** _____ - _____ (2 Digit Suffix)

Subscriber Name: _____ Your Relationship to Subscriber: _____

◆ **MEDICARE # INCLUDING SUFFIX** _____

PARENT/LEGAL GUARDIAN IS RESPONSIBLE FOR ANY UNCOVERED COSTS AND WILL BE BILLED

For insurances not accepted , the cost is \$30.00 **Cash** _____ **Check#** _____

Please answer the following questions:

- ◆ Are you allergic to eggs ? _____ Yes _____ No
- ◆ Have you ever been diagnosed with Guillain-Barre Syndrome? _____ Yes _____ No
- ◆ Do you have a fever today? _____ Yes _____ No
- ◆ Have you ever had a serious reaction to a flu shot? _____ Yes _____ No

If you answered **YES** to any of the questions **ABOVE**, you **MAY NOT** be able to receive a flu shot at this clinic.

- ◆ Have you ever had a flu shot before? _____ Yes _____ No
- ◆ Are you allergic to latex? _____ Yes _____ No

NOTE: TWO SIGNATURES ARE REQUIRED

INFLUENZA CONSENT:

I give my consent, voluntarily and of my own free will, to the medical staff to give my child a flu shot. I understand the risks and benefits of the flu vaccine, and have had all my questions answered. I waive any claims against the Center for Nursing Entrepreneurship, its officers, directors and employees arising out of my child's receipt of the flu vaccination whether caused by my negligence or the negligence of others. I also agree to provide my child's Primary Care Physician with a copy of my Certificate of Immunization. **Signature parent/legal guardian of vaccine recipient:**

X _____ Date: _____

I have had the opportunity to review or have been provided with a copy of the URM / Strong Health Notice of Privacy Practices.

X _____

Influenza Injection: Arm: Left Right

Sanofi Lot #: _____

Nurse: _____ Date: _____

The trivalent influenza vaccine prepared for the 2008-2009 season: A/Brisbane/59/2007 (H1N1)-like, A/Brisbane/10/2007 (H3N2)-like, and B/Florida/4/2006-like antigens.

www.cdc.gov/flu