635 Main St / 528 N. Monroe Ave
Green Bay, WI 54301
Phone (920) 437-0206
Fax (920) 437-8946

Inactivated Influenza Vaccination Consent Form

Last Name_____First_____MI_____Birthdate _____(>65years old=high dose)

Address, City, State, Zip_____

Phone_____ Commerical Insurance & Medicare Advantage – Include copy of front and back of card

Medicare B Number _____Medicaid Number _____

Have you ever had a serious reaction to influenza vaccine in the past? **Yes** **No**

Do you have an allergy to eggs or to a component of the vaccine? **Yes** **No**

Have you ever had Guillain-Barre Syndrome? **Yes** **No**

Are you moderately or severely ill today (e.g., fever, respiratory illness)? **Yes** **No**

Allergies_____**Health Conditions**(circle) Asthma, COPD, Diabetes, Depression,

Heart Disease, High Blood Pressure, High Cholesterol, Stroke, Other_____

Acknowledgment – I have been given a copy of the Vaccine Information Sheet for the vaccine I am receiving, and I have had a chance to ask questions. I hereby release and hold harmless any entities, their officers, directors and employees involved with promoting or facilitating these immunization services. I understand that serious injury or death can result from any vaccination and in consideration of receiving the vaccination I voluntarily assume the risk of and accept full liability for any and all injuries and death which may occur as a result of my vaccination. I understand there is no assurance that the vaccine will prevent flu. I understand the benefits and possible side effects of the vaccine and request that the vaccine be given to me.
Insurance Billing – Medicare B/Medicare Advantage/Medicaid plans can be billed for the cost of the vaccination and the administration fee. Streu's Pharmacy will manage the billing and administration of the vaccinations. The patient is responsible for any or all charges not covered by insurance.
HIPAA Receipt I acknowledge that I have received a copy of and understand the following Streu's Pharmacy forms:

1. Notice of Privacy Practices (NOPP) / Patient Bill of Rights and Responsibilities.
2. Billing Information Form / 30 Supplier Standards
3. Complaint Procedure
4. Red Cross Emergency Kit Information

I will notify the Pharmacist of changes in my PHI that could include, but are not limited to, the following: new medications, changes in directions for use of medication, allergies or drug reactions, address changes, insurance changes, or any health condition changes.

Signature _____ **Date** _____

For Pharmacy Use Only

Type of Vaccine	**Date given** (mo/day/yr)	**Route/ Site**	**Funding Source**	**Vaccine (Lot, Mfgr, Exp)** (circle one)	**Dose**	**Date on VIS** ____
Inactivated Influenza		IM / Arm L or R	P	Flulaval Quad GSK Lot: Fluad High Dose Seqirus Exp:	0.5mL	8/6/21

Signature of Vaccinator _____Date _____ Time _____WIR____

8/2/23 **WIR Last Flu Date**_____