Meridian Behavioral Healthcare, Inc.

FLU VACCINE CONSENT FORM

STAFF INFORMATION

Name: _____ Date of Birth: _____

Address: _____ Apt. or Unit #: _____

City: _____ State: _____ Zip: _____

Phone: (_____)_____

Do you have United Healthcare insurance? ☐ Yes ☐ No *(If yes, please list your Member ID below)*

Member ID#: _____

ACKNOWLEDGEMENT and AUTHORIZATION

Please mark YES or NO for each question.	**YES**	**NO**
Have you ever had the flu shot before today?		
Have you ever had a reaction to a previous flu shot?		
Are you allergic to eggs or egg products, dairy products, chicken proteins, vaccine components, latex products or Thimerosal?		
Are you sick or do you have a fever (>100° F)?		
Have you been sick or had a fever (>100° F) in the last 2 weeks?		
Do you have a history of Guillain-Barre Syndrome (GBS)?		
Are you pregnant?		

Note: If you answered "YES" to any question, you may not be eligible to receive the vaccine

- ◇ I authorize Meridian Behavioral Healthcare, Inc. (MBHCI) to bill my insurance carrier and authorize records to be released and reviewed by authorized representatives of my third party payer or employer as required for payment. I authorize this information to be released/reviewed by any federal or state agency as required by a regulatory or licensing body of that agency.
- ◇ I agree to release and hold free of harm MBHCI and the venue at which the vaccine is being provided, its employees, officers, directors, or affiliates from any and all liability that might arise from or is in any way connected with this vaccine.
- ◇ I have been provided and read a copy of the Vaccine Information Statement (VIS) from the Centers for Disease Control, which explains the risks and benefits. I have had the chance to ask questions before my vaccination.
- ◇ I understand it is recommended that, if this is a first vaccination, I will remain in the area for 15 minutes for assistance should any immediate reaction occur. I understand that if I experience any side effects, it is my responsibility to consult a physician at my expense.
- ◇ By signing below, I authorize MBHCI to give me an influenza vaccination and bill my insurance carrier (listed above).

Signature: _____ **Date:** _____

FOR ADMINISTERING / BILLING STAFF USE ONLY

Vaccine Type	Dose	Vaccine			Date Given	Route (IM, SQ)	Site Given (RA, LA)	Vaccine Info Statement	
		Lot #	Expiration	Manufacturer				Date on VIS	Date Given

Staff Administering	Staff Signature	Date

Insurance Provider Billed	Billed Date	Staff Completing	Staff Signature