TAYLOR REGIONAL HOSPITAL

FLU VACCINE CONSENT

Influenza is a highly infectious, serious respiratory illness that kills an average of 79,000 people yearly and hospitalizes more than 960,000 persons in the U.S. each year. All health care workers (HCW) are advised by all health organizations to take the influenza vaccine so as to decrease their risk of contracting the flu and passing it to patients or family. Taylor Regional Hospital supports the following facts and advises all of our employees to be vaccinated.

THE SIMPLE FACTS:

- The vaccine has been proven to reduce the risk of acquiring the flu and reduces the risk of flu-related hospitalizations.
- It is biologically impossible to get the flu from the vaccination.
- HCW who get the flu can begin to infect others 1-2 days before their own symptoms appear.
- The best way to protect our community (elderly, chronically ill and immune-compromised patients) is for all HCWs to be vaccinated.
- If you do not take the flu vaccine and start to exhibit flu like symptoms you may be restricted from working until you are no longer symptomatic

PLEASE ANSWER THE FOLLOWING QUESTIONS	Yes	No
Have you had a severe (life-threatening) allergy to a vaccine in the past?		
Have you had the paralytic illness Guillian-Barre' Syndrome?		
Do you have an allergy to eggs or egg products? (Egg-free vaccines are available)		
Are you moderately or severely ill at this time?		

I have been given the opportunity to ask questions and understand by signing below, I am consenting to the administration of the Influenza Vaccine and acknowledge receipt of the Influenza Vaccine VIS (8/15/19).

____

PRINT NAME **Birth Date**

______________________________________ **Yes No N/A**

Signature **Date** **Consent to bill insurance**

Date	Manufacturer	Lot#	Expiration Date	Site (Deltoid)	Administered by
				Left Right	

Reported Side Effects:______________________________________

NAME:______________________________ SEX: M____ F_____ DATE OF BIRTH ____/____/_____

LAST FIRST Middle

ADDRESS:______________________________ CITY:______________________________

STATE:__________ ZIP:__________ HOME PHONE:________________CELL PHONE:________________

SOCIAL SECURITY #:______________________

Primary Care Physician____________________

Does someone else other than the biological parent have guardianship? Yes/No

INSURANCE INFORMATION:

PRIMARY INSURANCE:__________________ SUBSCRIBER NAME:______________________

SUBSCRIBER DOB:_____/_____/_____ SUBSCRIBER SOCIAL SECURITY #:______________________

SUBSCRIBER ID:__________________________ GROUP#:__________________

SECONDARY INSURANCE__________________ SUBSCRIBER NAME:______________________

SUBSCRIBER DOB:_____/_____/_____ SUBSCRIBER SOCIAL SECURITY #:______________________

SUBSCRIBER ID:__________________________ GROUP #:__________________

Please complete and return both forms ASAP. Once the forms have been returned the student will be called to the nurse station within 1-3 days to receive their flu vaccine. Confirmation will be sent home.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance claims. Financial policy: By signing below, I agree that I have read and fully understand the financial policy set forth by TRH Medical offices and i agree to the terms of this policy. I also understand that the terms of this policy may be amended by the practice at any time without prior authorization to the patient. I have received a copy of the vaccine information sheet.

______________________________ ____________________ ______________

PARENT/GUARDIAN SIGNATURE RELATIONSHIP DATE