



Influenza Vaccine Administration Form

Name: _____ Company: _____

Allergies: _____

Do you have a severe allergy to eggs? YES NO

Have you ever had an allergic reaction to the flu shot?..... YES NO

Do you have a history of Guillain-Barre Syndrome within 6 weeks of receiving a previous vaccine? YES NO

Are you sick today with a fever? YES NO

I have read the information about influenza and influenza vaccine (VIS 8/19/2014). I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and the risks of the influenza vaccine and request that the vaccine be given to me or to the person named below for whom I am authorized to make this request.

Signature

Signature of parent or guardian if under 18

FOR CLINIC USE ONLY

Manufacturer: _____

Lot No. _____

Expiration: _____

Site: Left Deltoid
 Right Deltoid

Signature: _____

Date: _____



Patient Name, Date of Birth

CONSENT TO TREATMENT
Community Health and Wellness

I am presenting myself for examination and treatment in the hospital, and I voluntarily consent to the rendering of such care encompassing routine diagnostic procedures and medical treatment, by authorized agents and employees of the hospital, and by its medical staff, or their designees, as may, in their professional judgment, be deemed necessary or beneficial.

AUTHORIZATION TO RELEASE INFORMATION

I understand that Lowell General Hospital will provide copies of all or part of my medical record to physicians or any facility participating in my care.

I understand that information about my health may be disclosed to public health authorities charged with preventing or controlling disease.

** By signing below, I acknowledge that Lowell General Hospital (LGH) has informed me of their Notice of Privacy Practices for the protection and security of my healthcare information. I also acknowledge that upon request, LGH will provide me with a copy of their Notice of Privacy Practice.

FINANCIAL CONSENTS

Release of Information, Assignment of Benefits, Payment Guarantee

AUTHORIZATION TO RELEASE INFORMATION: Lowell General Hospital is authorized to release to any insurance companies having coverage on me (or to the employer if coverage is under a group insurance plan) any information pertaining to the diagnosis and/or procedures relative to this hospital admission.

ASSIGNMENT OF INSURANCE BENEFITS AND RIGHT OF RECOVERY: In consideration of services rendered, I hereby forever assign and give to Lowell General Hospital all rights, title and interest in the benefits payable for services rendered by said hospital, provided by my policy(ies) of insurance. This transaction shall be for the recovery on said policy(ies) of insurance, but shall not be construed to be an obligation of Lowell General Hospital to pursue any such right of recovery.

AUTHORIZATION TO CONTACT: I agree, in order for you to service my account or to collect any amounts I may owe, you, your agents, and your business associates may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. You, your agents, and your business associates may also contact me by sending text messages or e-mails, using any e-mail address I provide to you.

I understand that I will be billed separately for services rendered by independent physicians or physician groups utilized by this hospital during this period of treatment.

A Photostatic copy of this authorization shall be considered as effective and valid as the original.

Date / Time

Signature of Patient

Date / Time

Witness



Lowell General Hospital - Flu Vaccine Administration

DATE _____ TIME _____

X

EMPLOYEE Name (LAST, FIRST, Middle Initial)

Date of Birth

Sex

Social Security Number (optional)

Employee Address (Number, Street, City, State, Zip Code)

Employee Home Phone

Employee Cell Phone

Primary Care Doctor

Phone

Race(s) (optional)

Ethnicity(s) (optional)

Primary Language

NEXT OF KIN Name (LAST, FIRST, Middle Initial)

Date of Birth

Sex

Relationship to Employee

Next of Kin Address (Write SAME if same as Employee) (Number, Street, City, State, Zip Code)

Next of Kin Home Phone

Next of Kin Cell Phone

PRIMARY INSURANCE COMPANY and Address

Member ID#

Group#

Subscriber

Date of Birth

Relationship to Employee

SECONDARY INSURANCE COMPANY and Address

Member ID#

Group#

Subscriber

Date of Birth

Relationship to Employee

EMPLOYER of the SUBSCRIBER of the insurance

Employer Address (Number, Street, City, State, Zip Code)

Employer Phone