Influenza Vaccine Administration Form

Name: _______________________________ Age: ______ 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 8/7/2015). 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. I further authorize electronic access of my pharmaceutical records, if applicable, for treatment purposes. I understand that my records will only be accessed by authorized individuals.

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. Provided, however, this assignment and transfer shall not take away my standing to pay directly to Lowell General Hospital all benefits due under said policy(ies) by reason of services rendered therein. I will pay Lowell General Hospital for all charges in excess of the sums actually paid pursuant to said policy(ies).

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. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I have read this disclosure and agree that I may be contacted as described above.

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