MediNurse, Inc. Vaccination Consent

Your safety is our primary concern. MediNurse reccomends you remain on premises for 10 minutes after receiving your vaccination. If you choose to leave the vaccination area, you are doing so against medical advice.

PLEASE PRINT

First Name | **MI** | **Last Name**

Address Number | **Street Name**

City | **State** | **Zip-Code**

Age | Date of Birth | Sex | Area Code | Phone Number

Please answer the following questions

	Yes	No
Are you **under** the age of 18?	☐	☐
Are you currently ill or running a fever?	☐	☐
Are you prgenant or suspect so?	☐	☐
Have you had an allergic reation to Thimersol or contact solution?	☐	☐
Do you have an allergy to eggs, egg products, or chicken protein?	☐	☐
Do you have an allergy to latex?	☐	☐
Do you have a prior history of Gullian-Barre Syndrome?	☐	☐
Have you had a reaction from a previous flu or pneumonia shot?	☐	☐
Have you been instructed **NOT** to get a flu or pneumonia shot?	☐	☐

Based on your responses to the above questions the nurse may need to direct you to your physician to obtain your vaccination.

Assignment of Benefits

I authorize MediNurse Inc. to obtain pertinent information, medical or otherwise necessary to process the claim. I agree to pay the amount not paid if my charges are denied for any reason. I also agree to pay collection fees if this account is sent to an outside company for collections. I acknowledge the receipt of the Notice of Privacy Practices from MediNurse Inc. I authorize MediNurse Inc. the holders of medical information about me to release such information and medical records regarding my vaccination to MediCare its intermediaries, carriers, peer review organization, insurance companies and other third party payers and their agents for benefit. **PATIENT INITIALS**_____

I have read the Vaccine information statements and been explained the information about flu and/or pneumonia vaccine. Any questions I may have were answered to my satisfaction and understanding. I am requesting the vaccination/vaccinations be administered to me or the person named for whom I am authorized to make this request. I am authorizing MediNurse, Inc. to initiate emergency treatment if needed. I also aurhoized MediNurse, Inc. to bill and receive payment for vaccinations administered today. MediNurse is hereby released from all legal liability that may arise from the release of information forgoing purposes and those stated in the "Notice of Privacy Practice". I understand that in order for any of my health information to be released, MediNurse requires a signed release of information form on file. I understand all the risks and benefits involved and have a chance to ask questions.

OVER»»»»»»

I release MediNurse, Inc., its officers, employees, affiliates from any and all liability that may arise from or in any way connected with the vaccines on behalf of my heirs, personal representatives and myself.

I elect to receive the: ☐ Influenza Vaccination ☐ Pneumonia Vaccination

My primary insurance carrier is : ☐ Medicare Part B (F & P) ☐ Mercy Health Plans (F&P)

☐ GHP (All) F&P ☐ Premier Plus (F&P)

Insurance Id #

☐ Self pay Cash ☐ Self Pay Check

By signing below I agree the above statements are true to the best of my knowledge.

_____ _____

Patient/Guardian Signature Date

Office Use Only: Clinic Location:_____

Influenza Mfg: ☐ GSK ☐ Novartis Lot # _____ Exp _____/_____

Injection Site: Deltoid ☐ Right ☐ Left ☐ Other Reason:_____

Pneumonia Mfg: _____ Lot #_____Exp_____/_____

Injection Site: Deltoid ☐ Right ☐ Left ☐ Other Reason:_____

Nurse Signature_____Date_____

MediNurse, Inc.

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