PENDER MEDICAL CLINIC

958 Wellness Way Ste 1, Pender, NE 68047

☐ New Patient

INFLUENZA VACCINATION ASSESSMENT, RELEASE & CONSENT FORM

Name: ____ DOB:_____/_____/______ Age:_______ Gender: M F

(Patient Name)

Address: ____ City:________________ State:__________

Zip:__________________ Email:____ Phone:_____-_____-________

Would you like a link emailed to you to register for the Patient Portal? _________ Yes __________ No

If yes, must complete registration within 7 days of receiving your invitation or your link will be invalid.

Primary Insurance:___________________________________ Policy #____________________________________

Policy Holder Name:__________________________ Policy Holder DOB:___/___/________ Relationship to patient_________

Secondary Insurance:__________________________________ Policy #____________________________________

Policy Holder Name:__________________________ Policy Holder DOB:___/___/________ Relationship to patient_________

Question #5 to be answered day of vaccination

Please check answer

1. Are you allergic to chicken, eggs, or chicken feathers? ______ Yes ______ No

2. Are you allergic to thimerosal-containing products (eye contact lens solution) or mercury containing products (merthiolate)? ______ Yes ______ No

3. Have you ever had a reaction to a flu shot? ______ Yes ______ No

4. Have you previously been diagnosed with Guillain-Barre Syndrome? ______ Yes ______ No

5. **Are you ill with a fever *today* ? (to be answered day of vaccination)** ______ Yes ______ No

For any "yes" answers, consult physician before the administration of vaccine.

I have read the information of have had the information explained to me. I have had a chance to ask questions and these have been answered to my satisfaction. I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me, or to the person named above for whom I am authorized to make this request. I accept responsibility for seeking medical attention for any problems with this vaccination.

Signature:____ Date:____/____/2024

To be signed day of vaccination

NURSES ONLY

SITE: Right Arm______ Left Arm________ Lot #____________

ADMINISTERED BY:_____________________________________