Baraga County Memorial Hospital

2021 FLU VACCINE CONSENT RECORD

I have read the information about influenza and influenza vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and I request that it be given to me or to the person named below for whom I am authorized to make this request. (This year's clinic is spread over 4 days and drive through only. Attendees will be directed to drive around the right hand side of the hospital to the rear ambulance bay to receive their vaccination.

Individuals with last names A-G are invited to attend the October 11th, 2021 clinic 9am-12pm.
Individuals with last names H-M are invited to attend the October 12th, 2021 clinic 9am-12pm.
Individuals with last names N-S are invited to attend the October 18th, 2021 clinic 9am-12pm.
Individuals with last names T-Z are invited to attend the October 19th, 2021 clinic 9am-12pm.

PLEASE compete the marked patient portions and bring a hard copy of this document when you come to get your flu vaccination. Each person needs their own form. Clinic use areas must be left blank.

MEDICARE /HEALTHY MICHIGAN

This Box Clinic Use Only:
Place Insurance Card in This Box Once Document is Complete and Take Photo

PLEASE COMPLETE PATIENT PORTION

Are you sick today? ___Yes ___No

Do you have an allergy to eggs, latex, or to a component of the vaccine? ___Yes ___No

Have you had a serious reaction to flu vaccine in the past? ___Yes ___No

Have you had Guillain-Barre syndrome? ___Yes ___No

Do you have asthma? ___Yes ___No

PLEASE COMPLETE PATIENT PORTION
INFORMATION ON PERSON TO RECEIVE FLU VACCINE: Male_____ Female ______

NAME:____
(Please Print)

ADDRESS____
PO Box/Street *City* *State/ZIP*

PHONE ________________________ **BIRTHDATE** ________________________ **AGE**__________

SIGNATURE of person to receive vaccine or person authorized to request; includes permission to bill Medicare/Medicaid if eligible.

X____ **DATE**__________________________

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FOR CLINIC USE ONLY

Baraga County Memorial Hospital — *Clinic Identification*

11OCT21/ 12OCT21/ 18OCT21/ 19OCT21 — *Circle Date Vaccinated*

______________________________ *Manufacturer, Lot # & NDC #*

Version Date: 2021-2022 Formula
(In accordance with USPHS requirements)

- ☐ High Dose Quadrivalent 0.7ml ☐ Quadrivalent .5 ml
- ☐ Rt Deltoid ☐ Rt Thigh
- ☐ Lt Deltoid ☐ Lt Thigh
- ☐ Other______________________________

Injection Site

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Vaccine Administrator Signature & Title

Administrator Comments: ____