Baraga County Memorial Hospital

2022 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-I are invited to attend the October 11, 2022 clinic 8am-12pm. Individuals with last names J-R are invited to attend the October 12, 2022 clinic 8am-12pm. Individuals with last names S-Z are invited to attend the October 13, 2022 clinic 8am-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

		*PLEASE CO	MPLETE PATIENT PORTION
		Are you sick tod	ay?YesNo
		Do you have an allergy to eggs, latex, or to a component of the vaccine?YesNo	
This Box Clin Place Insurance Car Document is Comple	d in This Box Once	Have you had a sthe past?Yo	serious reaction to flu vaccine in esNo
		Have you had Gu YesNo	iillain-Barre syndrome?
		Do you have astl	nma?YesNo
*PLEASE COMPLETE PA INFORMATION ON PERS		VACCINE: Male	Female
NAME:			
(Please Print)			_
,			
ADDRESS			
PO Box/Stree	et	City	State/ZIP
PHONE	BIRTHDATE		AGE
SIGNATURE of person to recei	ve vaccine or person authorized	to request; includes permission	n to bill Medicare/Medicaid if eligible.
X	DATE_		
*********	**********	**********	*******
FOR CLINIC USE ONLY			
D	11.0.CT2022 / 1	100 CT2022 / 120 CT2022	
Baraga County Memorial Hospital Clinic Identification		12OCT2022 / 13OCT2022 ate Vaccinated	Manufacturer, Lot # & NDC # Version Date: 2022-2023 Formula (In accordance with USPHS
requirements) ☐ High Dose Quadrivalent 0.7ml ☐ Rt Deltoid ☐ Rt Thigh ☐ Lt Deltoid ☐ Lt Thigh	□ Quadrivalent .5 ml		
□ Other		Vaccine Admin	istrator Signature & Title
,			
Administrator Comments:			