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## **INSURANCE CONSENT FORM**

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Precautions	and	Con	traiı	ndic	atio	ns: Pi	lease	e che	eck Y	ES (	or N	O fo	r ea	ach	que	esti	on.											Υ	ES		NO	
1. Have you					-									-					ccin	e?												
2. Are you exhibiting symptoms other than mild coughing, runny nose and/or diarrhea?  3. Have you ever had a <b>severe (allergic)</b> reaction to any of the components in the influenza vaccine you will be																																
receiving today? (I.E. eggs, egg proteins, thimerosol, latex, gelatin, arginine, formaldehyde, gentamicin, polymyxin B, neomycin, etc.). <b>Anything other than hives?</b>																																
4. Do you have a history of Guillain-Barré syndrome (muscle weakness and possibly paralysis) within <b>6 weeks</b> of receipt of receiving an influenza vaccine?																																
CONTACT YOUR PHYSICIAN AND/OR HEALTHCARE PROVIDER BEFORE RECEIVING THIS VACCINE IF YOU CHECKED YES ON ANY OF THE ABOVE QUESTIONS.																																
5. Are you pr	egna	nt or	sus	pect	you	are p	regr	nant?	If ye	es, p	leas	e tall	k to	the	nu	rse	befo	re re	ecei	vin	g th	e in	flue	nza	ı va	ccin	e.					
INFLUENZA VACCINE ADVERSE REACTIONS																																
Because influenza vaccine contains only non-infectious purified viral proteins, it cannot cause influenza. An occasional case of respiratory disease following immunization represents coincidental illnesses unrelated to influenza immunization.															Ŭ																	
Mild Problems: Soreness, redness, or swelling where the shot was given. Hoarseness; sore, red or itchy eyes; cough, fever, aches, headache, itching, and fatigue. If these problems occur they usually begin soon after the shot and last 1-2 days.																																
	Severe Problems: Life-threatening allergic reactions from vaccines are very rare. If they do occur, it is usually within a few minutes to a few hours after the shot. The safety of vaccines is always being monitored. For more information, visit:															iot.																
www.cdc.gov	/vacc	inesa	afety	/Vac	cine	_Mon	itorin	ng/Ind	dex.h	tml a	and v	vww.	cdc	gov.	//va	ccin	esaf	ety/	Acti	viti	es/A	ctiv	ities	_In	dex	.htn	ıl					
									BEL								D B															
Quadrivalent - Multi-Dose       Quadrivalent - Multi-Dose       Senior Shot Pre-filled syringe 90653															ree 674	Pre	e-fille	ed s	yrin	ge		T-Free Pediatric Pre-filled syringe 90686										
☐ Flucelvax (4	Yrs+)					ıval (6				[	⊒ Flu	ıAD (	65 \	Yrs+)	)				Fluc	elva	ax (4	Yrs	+)				Fluz	one	(6 m	onths	+)	
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Lot#					t#			_		'	_01#_				_			LO	t#				_				ot#		_		9	
Dose 0.5 ml	-			E	ф Da	ıte:			_	•								VIS	S Ve	rsic	n Da	ate _			_							
Nurse's Signati	Nurse's Signature														Da	te of	f Se	ervic	e			_										
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Corporate Address: 7227 Lee DeForest Drive, Columbia, MD 21046, Phone No. 866-211-0001  Maxim Health Systems, LLC, Tax ID No. 52-1968516, provides services in AK, AL, AR, CA, CO, CT, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MS, MT, NC, ND, NE, NJ, NM, OH, OK, OR, PA, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, and WY.																																
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						OR S																										
I have read the opportunity to ask	ques	tions a	about	thes	e imn	nunizat	tions a	and I	have I	been	offere	ed a c	ору	of th	e Va	ccin	e Info	rmati	ion S	State	emen	t (VI	S) fo	r the	e va	ccine	(s) be	eing a	admin	istere	d. I as	k tha
the immunization( hereby release N	/axim	Healtl	h Sys	stems	: ("Ma	xim"),	any re	etail si	ite, gro	ocery	store	, phar	rma	су, сс	orpoi	ratior	n, sch	ool, s	scho	ol d	istric	t, ph	ysicia	ın aı	nd/o	r me	dical	direct	tor an	nd thei	r resp	ective
affiliates, subsidia mmunization(s). N	∕laxim	and th	ne oth	ner af	oreme	entione	d par	ties sh	nall no	t at ar	ny tim	e or to	an	y exte	ent w	/hats	oever	be li	able,	, res	spons	ible,	or in	any	/ way	y acc	ounta	ıble fo	r any	loss, i	njury,	death
or damage suffere penefits outweigh																																
the vaccine. I authorize the	releas	e of th	is im	muniz	zation	data/c	onsei	nt forn	n to m	y phy	/siciar	n, my i	insu	ırer/h	ealth	n plai	n or a	third	l part	ty d	esigr	atec	l by n	ny c	urre	nt or	future	e hea	lth pla	an or e	employ	er fo
use in health/dise or health care/sen																																
as defined by the Maxim's NOTICE	HIPA/	Priva	acy R	ule, t	he info	ormatio	on ma	ay be i	rediscl	losed	by th	e reci	pier	nt and	d no	long	er pro	otecte	ed by	the	priv	acy	regula	atior	ns. I	ackn	owled	dge th	nat I r	eceive	ed a co	ору о
provides, and for one of the Maxim Health S	other h	ealth d	care o	opera	tions.	This a	uthori	zation	shall	expire	e one	year f	from	the o	date	I sig	n it un	nless	I rev	oke	it so	oner,	in w	ritinç	g, by	certi	ified n	nail, re	eturn	receip	t requ	estec
that Maxim took in	reliar	ice on	this	autho	rizatio	on befo	re it r	eceive	ed not	ice of	my re	evoca	tion.		•															•		
If this Consent have full authorit	y to si	gn on I	beha	If of the	he pat	tient ar	nd ma						•										_	•			•		, .		_	
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Signature/Legal Guardian
Print Name