Consent Form for 2025-2026 Influenza Vaccination

Partners In Care

All fields required

Last Name	First Name (legal)	Middle Initial

Physical Address	City	State	Zip

Date of Birth (mm/dd/yyyy)	Phone	Gender

Mother's Maiden Name (first and last name)

Check one box and complete.

☐ I use a Medicare Advantage Plan (i.e. PacificSource Medicare Advantage)
(Medicare Advantage plans replace traditional Medicare as Primary Insurance)
Name of Plan: *Insurance ID#:*

☐ I use traditional Medicare
Medicare ID#:

☐ I use other employer or commercial insurance (i.e. Moda)
Name of Plan: *Insurance ID#:*

☐ I am on Medicaid for primary medical expenses (i.e. OHP or PacificSource Community Solutions)
Name of Plan: *Insurance ID#:*

ATTENTION: Do not have a flu vaccine if one or more of the following contraindications apply:

- **I am severely allergic to eggs.**
- **I have a fever greater than 100.5°.**
- **I had an allergic reaction to a flu vaccine in the past.**
- **I have a history of Guillain-Barre Syndrome.**
- **I had an allergic reaction to thimerosal (mercury-based preservative) in the past.**

Consent to Receive a Vaccine

I have read and understand the contraindications listed above and confirm that none of them apply to my present condition. I am aware that, as with all vaccinations, the rare possibility exists for an allergic or other serious, even fatal, reaction. I understand that a copy of the vaccine manufacturer's drug information sheet is available on request. I believe that I have sufficient information to make an informed consent. Believing that the benefits outweigh the risks, I assume full responsibility for any reactions that may result.

Signature of Patient or Authorized Representative **Representative's Phone Number** **Date**

Print Representative's Name **Relationship to Patient**

Staff Use Only

Administration of Vaccine (Peel off and apply vaccine sticker from syringe in this box.)

Printed name of administering nurse	Date	Location of Injection	○ Right Deltoid	○ Left Deltoid

○ Hospice ○ Home Health ○ Transitions ○ Family or Caregiver ○ Employee ○ Volunteer

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