TREASURE COAST Urgent Care

1050 SE Monterey Rd. Suite 101 • Stuart, FL 34994 • **772-419-0560**
www.tcurgentcare.com | Secure Fax: 772-403-2379

INFLUENZA CONSENT FORM

PATIENT AUTHORIZATION AND NOTICE

_____ _____ _____

Patient Name (print) Date of Birth Phone

I do hereby consent voluntarily, and of my own free will, to the immunization staff of the **Treasure Coast Urgent Care**, to give me the influenza vaccine. I have read or have had explained to me this information about influenza and the influenza vaccine.

I am under the age of 18.	☐ **YES**	**NO** ☐
I have an allergy to chicken eggs, chicken feathers or egg products.	☐ **YES**	**NO** ☐
I have an allergy to Thimerisol, and/or sulfites that cause a reaction.	☐ **YES**	**NO** ☐
I have prior history of Guillian-Barre' syndrome or have an active un-stabilized neurological condition.	☐ **YES**	**NO** ☐
I am currently pregnant.	☐ **YES**	**NO** ☐
I am ill and have an acute respiratory or other active infection or illness.	☐ **YES**	**NO** ☐
I have had a severe reaction and/ or have become ill after receiving the flu vaccine.	☐ **YES**	**NO** ☐
I have been instructed by my physician NOT to receive the flu vaccine.	☐ **YES**	**NO** ☐
I am currently a member of Medicare HMO (Health Management Organization).	☐ **YES**	**NO** ☐

I understand that the vaccine is being given by **Treasure Coast Urgent Care**, under the order of:
Michele Libman, MD, Medical Advisor (UPIN H06452), 1050 SE Monterey Rd. Suite 101 Stuart, Florida (772)419-0560. All sponsors and their subsidiaries, divisions, affiliates, officers, directors and employees, expressly disclaim any responsibility with respect to the vaccination procedure. My consent is given in light of this knowledge and in consideration of Treasure Coast Primary Care giving the influenza vaccine.

I for myself, my heirs, executors, and assigns hereby agree to release **Treasure Coast Urgent Care** and its affiliates, the officers, directors, and employees, from any and all claims arising out of, in connection with, or in any way related to my receipt of influenza vaccine as they apply to my individual health situation.

- **I certify that I am eligible for Medicare benefits under Part B. I understand that should Medicare deny payment, I will become responsible for payment in full to the Treasure Coast Primary Care.**
- **I certify that I have been given the CDC Influenza Vaccine Sheet before my injection. I have reviewed the information sheet and I do not feel I have any contraindications to the administration of the Flu Vaccine.**

_____ _____ _____

Signature of Recipient Print Name Date

_____ _____ GIVEN IN: ___ RIGHT ARM ___ LFT ARM

Vaccine Manufacturer Administration Date

Dx CODE: **V04.81** ADMINISTRATION CODE: **90656 G0008** Lot Number: _____ Exp. _____

Signature of Administrator: _____ Medicare Claim #: _____