MAXIM HEALTH SYSTEMS® MAXIM HEALTHCARE SERVICES®

Branch: ___-___ Clinic: _____

INSURANCE CONSENT FORM

Insurance Name: _____
Insurance ID No.: _____ **Group No.:** _____

First Name: _____ **Middle Initial:** _____
Last Name: _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Phone: ___-___-___ **Birthdate:** MM DD YYYY **Age:** _____ **Sex: (M/F)** _____

For recipients 18 years of age and under only: **Mother's Maiden Name:** _____

***Precautions and Contraindications:* Please check YES or NO for each question.**	**YES**	**NO**
1. Have you ever had an anaphylactic-type reaction to latex?	☐	☐
2. Are you allergic to chicken eggs and/or egg products?	☐	☐
3. Are you allergic to Thimerosal (used as a preservative in vaccines)?	☐	☐
4. Are you exhibiting symptoms other than mild coughing, runny nose and/or diarrhea?	☐	☐
5. Do you have a history of Guillain-Barré Syndrome?	☐	☐
6. Have you ever had a serious reaction after receiving the influenza vaccine?	☐	☐

CONTACT YOUR PHYSICIAN AND/OR HEALTHCARE PROVIDER BEFORE RECEIVING THIS VACCINE IF YOU CHECKED YES ON ANY OF THE ABOVE QUESTIONS.

For Women: Please check Yes or No

7. Are you pregnant or suspect you are pregnant? If yes, please talk to the nurse before receiving the influenza vaccine.	☐	☐

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.

Mild Problems: Soreness, redness or swelling where the shot was given. Hoarseness, sore or red eyes, cough, itchiness, fever, aches. If these problems occur they should begin soon after the shot and lasts 1-2 days.

Severe Problems: Fever, malaise, myalgia, and other systemic symptoms occur infrequently and most often affect persons who have had no exposure to the influenza virus antigens in the vaccine (e.g., young children). 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.

Immediate, presumable allergic reactions such as hives, angioedema, allergic asthma, or systemic anaphylaxis occur rarely after influenza immunization. These reactions probably result from hypersensitivity reactions in people with severe egg allergy and such people should not be given influenza vaccine. This includes people who develop hives, have swelling of the lips or tongue, or experience acute respiratory distress or collapse after eating eggs. People with documented immunoglobulin E (IgE)- mediated hypersensitivity to eggs, including those who have experienced occupational asthma or other allergic responses from occupational exposure to egg protein, may also be at increased risk of reactions from influenza vaccine.

In 1976, a type of influenza (swine flu) vaccine was associated with Guillain-Barré Syndrome (GBS). Since then, flu vaccines have not been clearly linked to GBS. However, if there is a risk of GBS from current flu vaccines, it would be no more than 1 or 2 cases per million people vaccinated. This is much lower than the risk of severe influenza, which can be prevented by vaccination.

THE VACCINE SHOULD NOT BE ADMINISTERED TO PEOPLE WITH ACUTE FEBRILE ILLNESSES UNTIL THEIR TEMPORARY SYMPTOMS HAVE ABATED. HOWEVER, MINOR ILLNESSES WITH OR WITHOUT FEVER SHOULD NOT CONTRAINDICATE THE USE OF INFLUENZA VACCINE, PARTICULARLY AMONG CHILDREN WITH A MILD UPPER RESPIRATORY TRACT INFECTION OR ALLERGIC RHINITIS. **CONTRAINDICATIONS: INFLUENZA VIRUS IS PROPAGATED IN EGGS FOR THE PREPARATION OF INFLUENZA VIRUS VACCINE; THUS, THIS VACCINE SHOULD NOT BE ADMINISTERED TO ANYONE WITH A HISTORY OF HYPERSENSITIVITY TO ANY COMPONENT OF THE VACCINE INCLUDING THIMEROSAL.**

☐ **INFLUENZA VACCINE**

☐ Right Deltoid _____ (Nurse Initials)

☐ Left Deltoid _____ (Nurse Initials) MFR: _____ LOT NO.:_____

Corporate Address: 7227 Lee DeForest Drive, Columbia, MD 21046, Phone No.: 866-211-0001, Tax ID No.: 52-1968516

CONSENT FOR SERVICES, MEDICAL RECORDS and HIPAA PRIVACY INFORMATION

I have read the adverse reactions associated with the influenza vaccine. A copy of the vaccine manufacturer's drug information sheet is available on request. Furthermore, I have also had an opportunity to ask questions about this immunization. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result. My medical record may be shared with my physician/insurance. I am requesting that the immunization be given to me or the person named below for whom I am the legal guardian. I, for myself, my heirs, executors, personal representatives and assigns, hereby release Maxim, any retail site, grocery store, pharmacy, corporation, Insurance Plan, physician and/or medical director and their respective affiliates, subsidiaries, divisions, directors, contractors, agents and employees, from any and all claims arising out of, in connection with or in any way related to my receipt of this immunization. Maxim and the other aforementioned parties shall not at any time or to any extent whatsoever be liable, responsible, or in any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccine described above.

_____ Initial **I AM A MEMBER OF THE INSURANCE PLAN LISTED ABOVE WHICH IS MY PRIMARY MEDICAL COVERAGE. I ACKNOWLEDGE MY BENEFIT PLAN PROVIDES FULL REIMBURSEMENT TO MAXIM OR I WILL BE RESPONSIBLE FOR PAYMENT.**

Maxim will use and disclose your personal and health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed **NOTICE OF PRIVACY PRACTICES** to help you better understand our policies in regards to your personal health information. I acknowledge that I have received a copy of the Notice of Privacy Practices. I agree to remain in the general area for at least 15 minutes after receiving the vaccine. I acknowledge that I have received the appropriate Vaccine Information Statement (VIS) issued by the US Centers for Disease Control and Prevention for the vaccine being administered.

Influenza (VIS version date): _____

X _____ Signature/Legal Guardian

_____ Date of Service

_____ Print Name

_____ Nurse's Signature

Please provide a copy of this form to your physician and/or healthcare provider for your permanent medical records.