

Branch: -Clinic:

INSURANCE CONSENT FORM

Insurance Name:
 Insurance ID No.: Group No.:

First Name: Middle Initial:
 Last Name:
 Address:
 City: State: Zip:
 Phone: -- Birthdate: MMDDYYYY 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you allergic to chicken eggs and/or egg products? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you allergic to Thimerosal (used as a preservative in vaccines)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you exhibiting symptoms other than mild coughing, runny nose and/or diarrhea? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have a history of Guillain-Barré Syndrome? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had a serious reaction after receiving the influenza and/or pneumonia vaccine? | <input type="checkbox"/> | <input type="checkbox"/> |

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, red or itchy eyes; cough, fever, aches. 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.
- In 1976, a type of inactivated 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 safety of vaccines is always being monitored. For more information, visit:

www.cdc.gov/vaccinesafety/Vaccine_Monitoring/Index.html and www.cdc.gov/vaccinesafety/Activities/Activities_Index.html

AREA BELOW TO BE COMPLETED BY THE NURSE

Influenza:

Vaccine:

- Fluvirin Q2037 Flulaval Q2036
 Fluzone Q2038 Afluria Q2035

Injection Site:

- Left Deltoid Right Deltoid
 Left Thigh (Infant only) Right Thigh (Infant only)

Lot #

Dose:

- 0.5 mL (36 months and older)
 0.25 mL (6-35 months only)

VIS Version Date Issued:

Nurse's Signature: _____ Date of Service: _____

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, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, 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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Maxim of New York, LLC, Tax ID 06-1643257, provides services in NY.

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. For participants attending an educational institution (school/college) or residing in Senior Living, Assisted Living and/or Skilled Nursing Facility Settings: A copy of this consent may be provided to the institution/Facility for inclusion in your medical record and continuity of your education and/or treatment/care at the Facility. 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.

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.

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.

Initial

X _____
 Signature/Legal Guardian

_____ Print Name