2018-2019 QUADRIVALENT INACTIVATED INFLUENZA VACCINE CONSENT

CAMPUS HEALTH CENTER
5200 Anthony Wayne Drive, Suite 115, Detroit, MI 48202 | (313) 577-5041

Name: _____ **DOB:** _____ **Age:** _____ **Sex**: *(circle)* Male Female Transgender Undefined

Primary USA Mailing Address: _____
Street *Apt/Box #*

☐ **Home**
☐ **Campus/Local** _____
☐ **Other:** *City* *State* *County* *Zip Code*

Primary Phone: _____ ☐ Home ☐ Cell ☐ Work **WSU Access Id Email:** _____

Insurance Name: _____ **ID Number:** _____ **Group #:** _____

Subscriber Name: _____ **Date of Birth:** _____ **Relationship to** ☐ Self ☐ Spouse **Subscriber:** ☐ Parent/Child

I authorize and consent to medical, diagnostic, therapeutic, and other procedures and treatment by the physicians, physician assistants, nurse practitioners and other staff at Nursing Practice Corporation, a Michigan non-profit corporation doing business as Campus Health Center ("Center"). I understand the risks of the medical treatment and procedures, and that the practice of medicine is not an exact science. No guarantees or promises have been made concerning the outcome of any procedures or treatment. I understand that I have the right to make decisions concerning my health care, including my right to refuse medical and surgical procedures. I understand that if any agent or employee of the Center AT ANY TIME sustains a percutaneous (through the skin), mucous membrane (through the mouth or eye), or open wound or other significant exposure to my blood or other bodily fluids, I may be tested for HIV (the virus that causes AIDS), Hepatitis B, Hepatitis C, and/or Syphilis, and I consent to such tests. Any changes in this consent must be initialed by the patient and a member of the Center staff and may result in the reduction of services.

SIGNATURE: _____ **DATE**: _____
(Parent or guardian must sign if patient is under 18, incompetent, disoriented or mentally unstable) *MM / DD / YY*

I have received and reviewed the Center's *Notice of Privacy Practices* that contains more detailed information about how, why and when the Center may use and disclose Protected Health Information ("PHI"), as defined by HIPAA. I acknowledge that the Center may, from time to time, change its privacy practices and agree that Center may use and disclose my PHI in accordance with its *Notice of Privacy Practices*.

SIGNATURE: _____ **DATE**: _____
(Parent or guardian must sign if patient is under 18, incompetent, disoriented or mentally unstable) *MM / DD / YY*

I certify that all information provided by me on this form is true and correct, that I fully understand the consents and authorizations given above, that I have been given ample opportunity to ask questions and that any questions have been answered satisfactorily, and that I am the Patient listed in this document or I am duly authorized by the Patient listed in this document to provide the consents and authorizations described herein and to sign this document. I hereby assign to the Center all rights to insurance payment for professional services provided by it. This assignment will remain in effect until it is revoked in writing by Patient or a person authorized to revoke it on Patient's behalf. A photocopy of this assignment is to be considered as valid as the original. I agree to pay to the Center for charges resulting from services rendered that are not covered by insurance or other third party payment. I agree all bills are due in full at the time of service. Should I fail to honor these obligations, I agree to pay any collection costs and attorney fees resulting from collection of my accounts.

SIGNATURE: _____ **DATE**: _____
(Parent or guardian must sign if patient is under 18, incompetent, disoriented or mentally unstable) *MM / DD / YY*

Reg Complete:

Please read and check your answer to the following questions:

☐Y ☐N Have you had a fever of 101° F. or higher in past 48 hours?
☐Y ☐N Have you ever had an allergic reaction to a previous influenza vaccination?
☐Y ☐N Do you have a severe allergy to eggs?
☐Y ☐N Have you ever had Guillan Barré Syndrome (a severe paralytic illness)?
☐Y ☐N Do you have an illness or take medication causing immunodeficiency?
☐Y ☐N Are you allergic to any medications? (please list): _____
☐Y ☐N Are you currently taking medicines on a regular basis? (please list): _____
☐Y ☐N I have read the Vaccine Information Statement (VIS) dated 08/07/2015 provided me about INFLUENZA vaccine and the benefits and risks associated with receiving INFLUENZA vaccination.

☐**Student** ☐**WSU Employee**
_____
Banner ID Number

I certify that I have read this form, that I fully understand the authorizations, acknowledgements, consents and waivers given above, that I was given ample opportunity to ask questions and that any questions have been answered satisfactorily. The signature below indicates my request and consent for the INFLUENZA vaccination.

_____ _____
Signature *Date*

Office Use Only:

Vaccine: Fluzone **Manufacturer:** Sanofi **Lot #:** **UJ005AC** **Expires:** 06/30/2019

Dosage: 0.5 cc IM **Site:** **R** or **L** Deltoid **Administered by:**_____ **Date:**_____

Chart Complete: