**INFLUENZA CONSENT FORM**

**Person receiving Flu immunization _____**

**Their Birth Date_____**

**Insurance Company: _____**

**Subscriber ID IF NOT ON FILE!!_____ Group Number_____**

**Have you received an injection in the last 30 days?_____**

Your health insurance may not pay for the item(s) or service(s) that are described below. The plan that you have chosen as your health insurer does not necessarily cover all of your health care cost. Insurance only pays for covered items and services. The fact that insurance may not pay for a particular service does not mean that you should not receive it, especially if your physician recommends that you receive this service.

**Description of Item(s) or Service(s): (please mark the circle for what choice is chosen)**

**INACTIVATED INFLUENZA VACCINE (injection)** ◯

**FLUMIST O**

Vaccine Information Statement Sheets have been made available, and I have had a chance to ask questions. I understand the benefits and risks of flu vaccine and request that the vaccine be given to me or the person named above for whom I am authorized to sign.

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**Responsible party signature: (person receiving vaccine or parent or guardian)**

**For Clinic Use:**

| | |
|---|---|
| **Date of Vaccination** | **VIS 08/15/2019** |
| **Flumist** | **Private** **VFC** |
| **Flu Shot (Sanofi)** | **Private** **VFC** |
| **LA RA LT RT** | **Initials:** |