Branch: ☐☐☐-☐☐ Clinic: ☐☐☐☐☐

IMMUNIZATION CONSENT FORM

First Name: Middle Initial:

Last Name:

Address:

City: State: Zip:

Phone: - - Birthdate: M M D D Y Y Y Y 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. Do you have sensitivity 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 and/or pneumonia 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. ☐ ☐

***Pneumonia Vaccine:* Please check YES or NO.** YES NO

1. Have you ever received the pneumonia vaccine before? ☐ ☐

If no, Maxim will administer the pneumonia vaccine. If yes, read Maxim's policy below to determine eligibility.

The ACIP recommends persons aged 19 through 64 years who smoke cigarettes and/or have asthma should receive a single dose of pneumonia vaccine.

Maxim WILL NOT give second doses of pneumonia vaccine except for those persons over the age of 65 years of age who received the pneumonia shot prior to 65 and it has been 5 years or more since the last pneumonia shot.

2. I have read the above policy and meet the criteria stated above to receive the pneumonia shot. ☐ ☐

For Women: Please check Yes or No

3. Are you pregnant or do you suspect you are pregnant? If yes, physician prescription required. ☐ ☐

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.

Local Symptoms: Slight soreness, redness, or swelling at the site of injection may occur in some recipients.

Systemic Symptoms: 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). If these problems occur, they usually begin soon after the shot and last 1 to 2 days. 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.

Unlike the 1976-1977 swine influenza vaccine, subsequent vaccine prepared from other virus strains has not been clearly associated with an increased frequency of Guillain-Barré Syndrome (GBS). Even if GBS were a true side effect, the very low estimated risk of GBS is less than that of severe influenza, which could be prevented by vaccination. Other neurological disorders, including encephalopathies, have been temporarily associated with influenza immunizations, but cause and effect has not been clearly established.

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.**

PNEUMONIA VACCINE ADVERSE REACTIONS

Local reactions at the injection site include soreness, warmth, erythema, swelling and induration. Less than 1% of recipients develop a fever, muscle aches, or more severe local reactions.

☐ **INFLUENZA VACCINE**	☐ **PNEUMOCOCCAL VACCINE**
☐ Right Deltoid ___________ (Nurse Initials)	☐ Right Deltoid ___________ (Nurse Initials)
☐ Left Deltoid ___________ (Nurse Initials)	☐ Left Deltoid ___________ (Nurse Initials)
MFR: ________________ LOT NO.:______________	MFR: ________________ LOT NO.:______________

PAYMENT INFORMATION

☐ 90658 Flu Injection G0008 Dx V04.81 $ ______________ ☐ Coupon Coupon No. ______________

☐ 90732 Pneumonia Injection G0009 Dx V03.82 $ ______________ **AMOUNT PAID $** ______________

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 and pneumococcal vaccines. 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 these immunizations. 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(s) 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, 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 or these immunization(s). 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 vaccines 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 AND CONFIDENTIALITY 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 and Confidentiality Practices. I agree to remain in the general area for at least 15 minutes after receiving the vaccine.

X ______________________________ ______________________________

Signature/Legal Guardian Date of Service

______________________________ ______________________________

Print Name Nurse's Signature

Please provide us with your e-mail address if you would like to receive a reminder for your next flu immunization or other upcoming wellness events ______________________________. [This information will be kept confidential and only be used for the stated purpose.]

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

MARGINAL WORDS