NAME:_____ SEX: M_____ F_____ DATE OF BIRTH _____/_____/_____

LAST FIRST Middle

ADDRESS:_____ CITY:_____

STATE:_____ ZIP:_____ HOME PHONE:_____CELL PHONE:_____

SOCIAL SECURITY #:_____

Primary Care Physician_____

Does someone else other than the biological parent have guardianship? Yes/No

INSURANCE INFORMATION:

PRIMARY INSURANCE:_____ SUBSCRIBER NAME:_____

SUBSCRIBER DOB:_____/_____/_____ SUBSCRIBER SOCIAL SECURITY #:_____

SUBSCRIBER ID:_____ GROUP#:_____

SECONDARY INSURANCE_____ SUBSCRIBER NAME:_____

SUBSCRIBER DOB:_____/_____/_____ SUBSCRIBER SOCIAL SECURITY #:_____

SUBSCRIBER ID:_____ GROUP #:_____

Please complete and return both forms ASAP. Once the forms have been returned the student will be called to the nurse station within 1-3 days to receive their flu vaccine. Confirmation will be sent home.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance claims. Financial policy: By signing below, I agree that I have read and fully understand the financial policy set forth by TRH Medical offices and i agree to the terms of this policy. I also understand that the terms of this policy may be amended by the practice at any time without prior authorization to the patient. I have received a copy of the vaccine information sheet.

_____ _____ _____

PARENT/GUARDIAN SIGNATURE RELATIONSHIP DATE

TAYLOR REGIONAL HOSPITAL
Eagles Nest

FLU VACCINE CONSENT

Patient Name_____ **DOB**_____**Homeroom**_____

Influenza is a highly infectious, serious respiratory illness that kills an average of 79,000 people yearly and hospitalizes more than 960,000 persons in the U.S. each year.

THE SIMPLE FACTS:

- The vaccine has been proven to reduce the risk of acquiring the flu and reduces the risk of flu-related hospitalizations.
- It is biologically impossible to get the flu from the vaccination.

PLEASE ANSWER THE FOLLOWING QUESTIONS	Yes	No
Have you had a severe (life-threatening) allergy to a vaccine in the past?		
Have you had the paralytic illness Guillian-Barre' Syndrome?		
Do you have an allergy to medications/food/vaccine component/latex?		
Are you moderately or severely ill at this time?		

I have been given the opportunity to ask questions and understand by signing below, I am consenting to the administration of the Influenza Vaccine and acknowledge receipt of the Influenza Vaccine VIS (8/6/21)

_____

Signature **Date**

Completed by staff:

Date Time	Manufacturer	Lot#	Expiration Date	Site (Deltoid)	Administered by	VFC or Private
				Left Right		

Reported Side Effects:_____