Flu Vaccine Consent Form

(Please print clearly)

Client LAST Name

Client FIRST Name

/ /

Date of BIRTH **Cell phone**

EMAIL: _____

Address

City **State** **Zip Code**

I am not severely allergic to eggs and understand that the following minor reactions may occur after Flu Immunization:

- Mild to moderate soreness at the vaccination site lasting 1 -2 days.
- Mild symptoms (not the flu) with aches and low fever lasting 1 - 2 days.

I have not had a reaction to a flu vaccine. I do not have a history of Guillain-Barre Syndrome.

I have read the Vaccine Information Statement; I understand the benefits and risks of receiving the flu vaccine. I will not hold Flu Busters, LLC, building owners or administrators, agency, company, employer, or school liable for any harm, adverse side effects, or other consequences caused by receiving the flu vaccine.

Signature_____ (if under age 18, parent signature required) **Date**: _____

_____**(initial)** I understand that the privacy practices of Flu Busters, LLC are in compliance with the Health Insurance portability and Accountability Act (HIPAA). I will view it and print a copy of this Act at my convenience by visiting www.texasflubusters.com. I also understand that I may request a copy from Flu Busters, LLC staff.

We will submit claims to Blue Cross Blue Shield or United Healthcare Insurance for payment. Please check with your insurance carrier to verify flu vaccination is covered under your policy. **Some plans REQUIRE you to have a Primary Care Physician on file for vaccination to be covered in-network. If vaccine is not covered, you will be responsible for payment. **We are not a Medicare provider and we cannot submit claims to Medicare** for payment.

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For Office Use Only

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Lot # Member ID:

RN