HS HEALTHY SOLUTIONS, INC.

FLU VACCINATION
5 Years and Older
CONSENT FORM

PARTICIPANT TO COMPLETE - PLEASE PRINT LEGIBLY

Print Name: _____ Sex: ☐M ☐F *Check One* Phone: (_____) _____ -_____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ / _____ / _____ Age: _____ E-mail Address: _____
MM *DD* *YY* (5 years & older)

PLEASE CHECK YES OR NO FOR EACH QUESTION

	YES	NO
1.Are you allergic to eggs, egg proteins, thimerosal or any component of the vaccine?	☐	☐
2.Have you had a previous serious allergic reaction to the flu shot?	☐	☐
3.Do you have a current fever; or moderate or severe illness?	☐	☐
4.Do you have a history of Guillain-Barré Syndrome?	☐	☐
5.FOR WOMEN: Are you pregnant? If yes, you CAN receive the flu shot.	☐	☐

If you answered "yes" on questions 1-4 above you can NOT receive the vaccination at this time. Consult with your physician.
If you have any questions, ***please ask now before receiving the vaccine.*** *If you experience any significant delayed reactions,* ***SEE YOUR PHYSICIAN.***

Children 5-8 years of age...Children age 5 through 8 years who are receiving seasonal flu vaccine for the first time should get a second dose 4 weeks or more after the first dose. Children age 5 through 8 years of age who received two or more total doses in their lifetime will need one dose. **Children 9 years and older** should receive 1 dose of flu vaccine. **Healthy Solutions is NOT responsible for providing or coordinating the second dose, if needed.**

PRESENT YOUR INSURANCE CARD AT THE CLINIC - MUST BE PRIMARY **PLEASE CHECK WITH YOUR INSURANCE TO VERIFY COVERAGE**

☐ Aetna (**No** HCA)
☐ Meritain Health (**No** AdventHealth)
☐ All Savers
☐ Blue Cross (**NO** NKC Hospital / **NO** OEG, KWF)
☐ Cigna (**No** EPO Connect / SureFIT)
☐ Humana (**No** Humana One, PPOX)
☐ United Healthcare (**No** Core Plans)
☐ UMR ☐ GEHA ☐ UnitedHealth Shared Services

☐ Aetna Medicare
☐ Blue Medicare Advantage
☐ Humana Medicare Health Plan
☐ United Healthcare Medicare Solutions
☐ Medicare Part B **MUST BE PRIMARY**
☐ Railroad Medicare Part B **MUST BE PRIMARY**

We do NOT accept Tricare, Medicaid or ACA Marketplace Plans (Blue Cross ACA Marketplace is accepted)

Print Name _____
(NAME OF PERSON RECEIVING VACCINE - EXACTLY AS LISTED WITH INSURANCE COMPANY)

Member ID # _____ _____
(REQUIRED FOR ALL INSURANCES LISTED ABOVE) (SUFFIX)

For Healthy Solutions Staff ONLY

☐Cash
☐Check # _____
Amount Paid $_____
☐ Employer Paid
☐ Healthy Solutions Coupon

I have been offered a copy of the "Vaccine Information Statement" for the vaccine(s) I receive today. I have read the information about the influenza vaccine and I have had a chance to ask questions. I understand the benefits and risks of the influenza vaccination and request that the vaccine be given to me or the person named above for whom I am authorized to sign. I agree that Healthy Solutions, Inc. is not responsible or liable if I contract influenza, other respiratory diseases, or suffer any other adverse reaction or event following administration of the influenza vaccine. This vaccination is being given to me at my request. As a condition of receiving the vaccine, I, myself, my heirs and executors hereby waive any right I may have to make a claim against Healthy Solutions, Inc. and the sponsoring organization, their affiliates, divisions, subsidiaries, officers, directors, advisory boards, employees, and contractors from any and all claims arising out of, in connection with, or in any way related to my receiving the influenza vaccine. I authorize Healthy Solutions, Inc. to furnish information to and receive payment from insurance companies for services provided me. I understand that these records may be protected by Federal Regulations and have been offered Healthy Solutions, Inc.'s Notice of Privacy Practices. In order to provide program participation Healthy Solutions, Inc. may provide my name to the sponsoring organization or its designated representative. I agree that Healthy Solutions, Inc., its agents and employees, are not liable if individuals or companies to whom they release information disclose the information without my consent. I accept responsibility for seeking medical attention for any problems associated with my receiving the vaccination.

I AGREE TO WAIT IN THE AREA FOR 15 MINUTES AFTER RECEIVING THE VACCINATION(S).

The acceptance of your health insurance information does not guarantee coverage or payment by your insurance company.
I fully understand that I will be responsible for charges if insurance or Medicare does not pay.

Participant Signature_____ Date:_____
(or Legal Guardian if 5 -17 years old)

Manufacturer	Lot	Exp. Date	Injection Site	Vaccine	Nurse Signature
			❑R Deltoid ❑L Deltoid	❑Vial ❑Prefilled Syringe	