



Branch: - Clinic:

IMMUNIZATION CONSENT FORM

First Name: Middle Initial:

Last Name:

Address:

City: State: Zip:

Phone: -- Birthdate: - Age: Sex: (M/F)

Employee ID: Mother's Maiden Name:

For recipients 18 years of age and under only:

Precautions and Contraindications: Please check YES or NO for each question.

1. Have you ever had an anaphylactic-type reaction to latex?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
2. Are you allergic to chicken eggs and/or egg products?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you allergic to Thimerosal (used as a preservative in vaccines)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you exhibiting symptoms other than mild coughing, runny nose and/or diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have a history of Guillain-Barré Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had a serious reaction after receiving the influenza and/or pneumonia vaccine?	<input type="checkbox"/>	<input type="checkbox"/>

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. YES NO

Pneumonia Vaccine: Please check YES or NO.

1. Have you ever received the pneumonia vaccine before? YES NO

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. YES NO

For Women: Please check Yes or No:

3. Are you pregnant or do you suspect you are pregnant? If yes, physician prescription required. YES NO

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.

Mild Problems: Soreness, redness, or swelling where the shot was given. Hoarseness; sore, red or itchy eyes; cough, fever, aches. If these problems occur they usually begin soon after the shot and last 1-2 days.

Severe Problems:

- Life-threatening allergic reactions from vaccines are very rare. If they do occur, it is usually within a few minutes to a few hours after the shot.
- In 1976, a type of inactivated influenza (swine flu) vaccine was associated with Guillain-Barré Syndrome (GBS). Since then, flu vaccines have not been clearly linked to GBS. However, if there is a risk of GBS from current flu vaccines, it would be no more than 1 or 2 cases per million people vaccinated. This is much lower than the risk of severe influenza, which can be prevented by vaccination.

The safety of vaccines is always being monitored. For more information, visit:
www.cdc.gov/vaccinesafety/Vaccine_Monitoring/Index.html and www.cdc.gov/vaccinesafety/Activities/Activities_Index.html

PNEUMONIA VACCINE ADVERSE REACTIONS

Mild Problems: About half of people who get PPSV have mild side effects, such as redness or pain where the shot is given. Less than 1% develop a fever, muscle aches, or more severe local reactions.

Severe Problems: A vaccine, like any medicine, could cause a serious reaction. But the risk of a vaccine causing serious harm, or death, is extremely small.

AREA BELOW TO BE COMPLETED BY THE NURSE

<p><input type="checkbox"/> Influenza Vaccine:</p> <p><input type="checkbox"/> Fluvirin Q2037 <input type="checkbox"/> Flulaval Q2036</p> <p><input type="checkbox"/> Fluzone Q2038 <input type="checkbox"/> Afluria Q2035 Lot # _____</p> <p>Injection Site:</p> <p><input type="checkbox"/> Left Deltoid <input type="checkbox"/> Right Deltoid</p> <p><input type="checkbox"/> Left Thigh (Infant only) <input type="checkbox"/> Right Thigh (Infant only)</p> <p>Dose: <input type="checkbox"/> 0.5 mL (36 months and older)</p> <p><input type="checkbox"/> 0.25 mL (6-35 months only)</p> <p>VIS Version Date Issued: _____</p>	<p><input type="checkbox"/> Pneumococcal Vaccine:</p> <p><input type="checkbox"/> Merck <input type="checkbox"/> Other _____</p> <p>Lot # _____</p> <p>Injection Site:</p> <p><input type="checkbox"/> Left Deltoid <input type="checkbox"/> Right Deltoid</p> <p>Dose: <input type="checkbox"/> 0.5 mL</p> <p>VIS Version Date Issued: _____</p>
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Nurse's Signature: _____ **Date of Service:** _____

PAYMENT INFORMATION

	Amount Paid
<input type="checkbox"/> 90658 (or vaccine specific Q code above) Flu Injection G0008 Dx V04.81	\$ _____
<input type="checkbox"/> 90655 Preservative Free, 6-35 Month Flu Injection G0008 Dx V04.81	\$ _____
<input type="checkbox"/> 90657 Multidose Vial, 6-35 Month Flu injection G0008 Dx V04.81	\$ _____
<input type="checkbox"/> 90732 Pneumonia Injection G0009 Dx V03.82	\$ _____

Corporate Address: 7227 Lee DeForest Drive, Columbia, MD 21046, Phone No. 866-211-0001

Maxim Health Systems, LLC, Tax ID No. 52-1968516, provides services in AK, AL, AR, CA, CO, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MS, MT, NC, ND, NE, NJ, NM, OH, OK, OR, PA, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, and WY.

Maxim Healthcare Services, Inc., Tax ID 52-1590951, provides services in AZ, MO, NH, NV, and RI.

Maxim of New York, LLC, Tax ID 06-1643257, provides services in NY.

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. For participants attending an educational institution (school/college) or residing in Senior Living, Assisted Living and/or Skilled Nursing Facility Settings: A copy of this consent may be provided to the institution/Facility for inclusion in your medical record and continuity of your education and/or treatment/care at the Facility. 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, school, school district, 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 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 Practices. I agree to remain in the general area for at least 15 minutes after receiving the vaccine. I acknowledge that I have received the appropriate Vaccine Information Statement (VIS) issued by the US Centers for Disease Control and Prevention for the vaccine(s) being administered.

X _____ Signature/Legal Guardian _____ Print Name _____

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.