INSURANCE BILL

SANFORD HEALTH

Sanford Health Occupational Medicine Clinic
Influenza Vaccine Consent & Documentation Form

Date: _____ **Company:** _____

Legal First Name: _____ **Last Name:** _____ **DOB:** _____

Address: _____ **City:** _____ **State:** ___ **Zip:** _____ **Gender:** ____

Home Phone:_____ **Mobile Phone:** _____ **Work Phone:**_____

Is Insurance Carrier Sanford Health Plan? Yes____ No ___

If answer is NO and you do not have a copy of your insurance card, please complete below insurance information.

Insurance Carrier: _____ **Insurance Number:** _____

Group Number (if applicable): _____ **Insurance Effective Date:** _____

Relationship to Subscriber of Coverage: _____

Subscriber's Full Name: _____ **Subscriber DOB:** _____

Copy of both sides of insurance card must be obtained prior to vaccination if prior insurance information was not obtained as noted/documented above. I assign and authorize my third party payer/insurer to make payment directly to Sanford Health Occupational Medicine. My signature also authorizes entry of this vaccination into my Sanford Health electronic medical record and state vaccine registry

I have read the influenza vaccine information sheet or have had explained to me the information about the influenza vaccine. I have had an opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine and request that it be given to me or the person(s) named for whom I am authorized to make this request. I release Sanford Health and my employer from any liability of complications or injuries which may result from the administration of the vaccine.

Employee Consent Process	**Yes**	**No**	**Don't Know**
1. **Is the person to be vaccinated sick today?**	☐	☐	☐
2. **Does the person to be vaccinated have an allergy to eggs, a component of the vaccine or latex?** (if thimerosal allergy, give 0.5ml dose of adult preservative free vaccine)	☐	☐	☐
3. **Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?**	☐	☐	☐
4. **Has the person to be vaccinated ever had Guillain-Barre` Syndrome?** (If yes, do not vaccinate and refer to primary care provider)	☐	☐	☐

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been offered a copy of Sanford Health's Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed and outlines my rights with respect to such information. The Notice of Privacy Practices may be changed at any time. I may obtain a copy of the Notice from any Sanford Health location or at www.sanfordhealth.org

Patient Signature: _____ Date: _____

Manufacturer Name: Sanofi Pasteur Fluzone quadrivalent vaccine
Dose: * 0.5ml – Adult preservative free (pre-filled syringe)
Lot number: _____ **Expiration Date:** _____
Route: Intramuscular site (circle one): R Deltoid - L Deltoid

Vaccine sticker

_____ Date: _____Administering Nurse / Title