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IMMUNIZATION CONSENT AND RELEASE

CPT 90663
HCPCS G9141

Care Dynamix Inc dba Flu Busters

First Name **MI** **Last Name**

Number & Street Address

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

Phone Number - - **Birth Date** / / **Age**

☐ Male
☐ Female

Name of School (where receiving vaccination)

H1N1 VACCINE

The H1N1 flu vaccine does not protect against all strains of the influenza virus. The ability of flu vaccine to protect a person depends on the age and health status of the person receiving the vaccine, and the similarity or "match" between the virus strains in the vaccine and those in circulation. If you question whether you should receive the flu vaccine, please contact your personal physician. A small percentage of those vaccinated may experience minor side effects, such as soreness around the vaccination site for up to two days, headache or low-grade fever. Immediate, presumably allergic, reactions such as hives, angiodema, allergic asthma or anaphylaxis occur rarely after influenza vaccination. These reactions probably result from hypersensitivity to some vaccine component - the majority of reactions are most likely related to residual egg protein. Individuals with anaphylactic hypersensitivity to eggs should not be given an influenza vaccine. Guillain-Barre Syndrome (GBS) was noted to be a rare sequel of influenza vaccination during the 1976 "swine" influenza immunization program. Please contact your personal physician in the event of a reaction. Because of the potential for allergic reaction, you will be asked to remain in the immediate area for observation purposes for the next 20 minutes after receiving the vaccine.

PLEASE ANSWER ALL QUESTIONS. Please check "YES" or "NO"

1. Has your child received an H1N1 shot with in the last 28 days? ☐ YES ☐ NO
2. Is your child allergic to eggs? ☐ YES ☐ NO
3. Has your child ever had a serious allergic reaction to the influenza (flu) vaccine or to any other type of vaccine? ☐ YES ☐ NO
4. Has your child ever had Guillain-Barre syndrome (a paralyzing illness)? ☐ YES ☐ NO
5. Has your child received a MMR and/or Varicella (chickenpox) and/or nasal flu vaccine in the past month? ☐ YES ☐ NO
6. Could your child be pregnant? ☐ YES ☐ NO
7. Does your child have any long term medical condition or a weakened immune system? ☐ YES ☐ NO
   a. If yes, please write the medical condition(s): _____
8. Does your child have asthma? ☐ YES ☐ NO
9. Does your child take aspirin every day? ☐ YES ☐ NO
10. Does your child have close contact with a person who needs to be in a protected medical environment (for example, someone who has recently had a bone marrow transplant)? ☐ YES ☐ NO

By signing this form below, I understand that, depending on the answers to the questions above, I will receive either the injectable or the nasal flu vaccine(s) at the clinic. I give permission to receive the H1N1 influenza (flu) vaccine.

WAIVER AND RELEASE

I hereby release and forever discharge and hold harmless Flu Busters and its directors, officers, employees, agents and assigns, any retail site, grocery store, pharmacy, corporation, physician and/or medical director and their respective directors, officer, employees, agents and assigns (hereinafter, collectively referred to as "Releasees") from any and all liability, claims, demands, and causes of action of whatever kind of nature, either in law or equity, which may hereafter arise from my child's receipt of the flu vaccine. I understand and acknowledge that this Consent and Release discharges Releasees from any liability or claim that may arise as a result of my child's receipt of the flu vaccine, with respect to any bodily injury or other injury, including any mental injury, illness, death, or property damage that may result. I understand that Releasees do not assume any responsibility or obligation to provide financial assistance or other assistance, including, but not limited to medical, health, or disability insurance, in the event of injury, illness, death or property damage, unless otherwise expressly governed by and interpreted in accordance with the laws of the governing State where I receive my vaccination. I agree that in the event that any clause or provision of this Release shall be held to be invalid by any court of competent jurisdiction, the invalidity of such clause or provision shall not affect the remaining provisions of this Consent and Release.

☐ **I HAVE RECEIVED, READ AND UNDERSTAND THE 2009-2010 NOVEL H1N1 VACCINE INFORMATION STATEMENT. I HAVE HAD THE CHANCE TO ASK QUESTIONS AND DISCUSS MY CONCERNS WITH A HEALTHCARE PROFESSIONAL (please check box if "yes" and MUST be checked to receive vaccine).**

INFORMED CONSENT AND HIPAA PRIVACY INFORMATION

I have read the above Consent and Release and understand its provisions and applicability. I understand the benefits and risks of the flu vaccine as described and request that the vaccine be given to me or the person named above for whom I am the legal guardian. My medical record may be shared with my physician and/or insurer. I understand that Flu Busters will use and disclose my personal health information to treat me, to receive payment for the care it provides me, and for other health care operations, which generally include activities to improve the quality of care. I acknowledge that I have received a copy of Flu Busters' NOTICE OF PRIVACY AND CONFIDENTIAL PRACTICES. I hereby freely and voluntarily, without duress, execute this Consent and Release under the above written terms.

PAYMENT INFORMATION

Any returned checks or denied credit card transactions are subject to the maximum allowed fee. Medicare MUST be your primary provider to be accepted or it will be denied and you will owe the full shot amount.

CASH AMOUNT $.

CHECK NUMBER **CHECK AMOUNT** $.

If your check is dishonored or returned for any reason, we will electronically debit your account for the amount of the check plus a processing free of $30.

CREDIT CARD AMOUNT $.

CREDIT CARD TYPE ☐ Visa ☐ MasterCard ☐ Discover

SIGNATURE

CREDIT CARD NUMBER

CREDIT CARD EXPIRATION /

SECURITY CODE

Your credit card billing address MUST be the same as it is listed above. If your billing address is different, please write your billing address on the reverse side of this form.

MEDICARE, MEDICAID OR INSURANCE

NOTE: Your Medicare, Medicaid or Insurance number could have a letters prefix AND/OR letters suffix, or neither. Please enter information as it appears on your card in the space provided. Do NOT include dashes.

Your name at the top of this form MUST be the same as it is listed with your provider and as it appears on your card. I attest the listed provider is my PRIMARY medical coverage or I will be charged for the vaccination plus the service fee.

VOUCHER/TICKET NUMBER

NURSE INFO ONLY

Injectable Vaccine
Nurse Initials _____ Mfr. _____ Lot # _____
check one: ☐ Right Deltoid ☐ Left Deltoid

Nasal Spray
Nurse Initials _____ Mfr. _____ Lot # _____

Signature (or Legal Guardian) _____ **Date** _____

Print Name _____ **Nurse's Signature** _____