2867050615

FLUMIST CONSENT AND RELEASE

Care Dynamix Inc dba Flu Busters

CPT 90660
DX V04.81

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

Number & Street Address

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

Phone Number **Birth Date** **Age**

☐ Male ☐ Female

FLUMIST VACCINE

FluMist does not protect against all strains of the influenza virus. The ability of Flu Mist to protect a person depends on the age and health status of the person getting the FluMist and the similarity or "match" between the virus strains in the FluMist and those in circulation. FluMist is an influenza vaccine that is given as a mist into the nose. FluMist contains live influenza virus strains that have been weakened. When the weakened influenza viruses in FluMist enter the nose, the body develops an immune response that may help prevent the flu for the entire season. If you question whether you should receive FluMist, please contact your personal physician. Those vaccinated may experience generally mild and temporary side effects, such as runny nose/nasal congestion, cold-like symptoms, cough, sore throat, headache, chills, muscle aches, tiredness, weakness, irritability, vomiting and fever > 100 degrees Fahrenheit. If you have an adverse reaction, please contact your nurse or physician right away. Children under 9 years of age receiving the influenza vaccine for the first time should get 2 doses of vaccine at least one month apart. **Because of the potential for allergic reaction, you are asked to remain in the immediate area for observation purposes for the next 20 minutes after receiving the vaccine. You must answer the following questions prior to receiving the vaccine. CHECK "YES" OR "NO" FOR EACH QUESTION:**

1. Have you ever had a Pneumonia shot before? If yes, when? _____	☐ Yes	☐ No
2. Are you currently receiving chemotherapy, radiation therapy or immunosuppressive therapy or are you having these therapies within the next two weeks?	☐ Yes	☐ No
3. Are you pregnant or currently nursing a baby?	☐ Yes	☐ No
4. Have you ever had an adverse reaction to another vaccine? If yes, what? _____	☐ Yes	☐ No
5. Do you have a past history of Guillian-Barre syndrome?	☐ Yes	☐ No
6. Do you have hypersensitivity to any component of the vaccine?	☐ Yes	☐ No
7. Are you allergic to nowmycin, thimerosal or streptomycin?	☐ Yes	☐ No
8. Do you have a history of sensitivity to latex?	☐ Yes	☐ No
9. Have you had Pneumonia within the past year?	☐ Yes	☐ No
10. Are you currently receiving any blood thinners such as coumadin or heparin, or receiving aspirin therapy?	☐ Yes	☐ No
11. Do you currently have a fever or respiratory illness or any other type of infection?	☐ Yes	☐ No

If you checked "Yes" on any of the above questions, please contact your physician and/or health care provider before receiving this 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 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 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 State of Georgia. 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.

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 LETTERS PREFIX

MEDICARE NUMBER - -

MEDICARE LETTERS SUFFIX

NOTE: Your Medicare number could have a letters prefix AND/OR letters suffix, or neither. Please enter information as it appears on your card.

Your name at the top of this form MUST be the same as it is listed with your Medicare provider and as it appears on your Medicare Card. Participants with Medicare HMO must pay for services. I attest Medicare Part B is my PRIMARY medical coverage or I will be charged for the vaccination plus the service fee.

VOUCHER/TICKET NUMBER

NURSE INFO ONLY
☐ Right Deltoid Nurse Initials _____ Mfr. _____
☐ Left Deltoid Nurse Initials _____ Lot # _____

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.

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

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

BOTTOM COPY = Give to Flu Mist Recipient

TOP COPY = Return to Flu Busters