Acadiana Center
2501 West Pinhook Road; Lafayette, LA 70508
Phone (337) 269-0136 Fax (337) 233-8525

Inactivated Influenza Vaccine Consent 2016/2017

Patient Name: Last ______________________ First ______________________ MI ________

Date of Birth: ____/____/______ Social Security #: _____-_____-______ Gender: ☐ Male ☐ Female

Mailing Address: ____

City: ______________________________ State: ________ Zip: ____________

Home Phone: (____)______-________ Cell: (____)______-________ Other: (____)______-________

Email: ______________________________

Emergency Contact (not living with you): ______________________ Phone Number: (____)______-________

Potential Contraindications	**Yes**	**No**
Are you currently ill and/or have fever?	_____	_____
Have you ever had a severe reaction to an influenza vaccine and/or egg protein?	_____	_____
Are you allergic to the preservative thimerosal? *Important only for multi-dose vial, regular strength intra-muscular vaccinations.*	_____	_____
Have you ever had Guillain-Barre Syndrome (GBS)? *Guillain-Barre Syndrome has not been associated with the influenza vaccine (1 per 100,000) since 1976. However, individuals with a history of GBS should Discuss immunization with their health care provider prior to receiving the vaccine.*	_____	_____
Is your immune system compromised by disease and/or medication? *The vaccine may be given, but the desired immune response may not be obtained.*	_____	_____

Please explain any "Yes" responses ______________________________

AUTHORIZATION FOR TREATMENT AND RELEASE OF MEDICAL INFORMATION

I hereby authorize any provider of Acadiana Center to evaluate and or treat the patient. I authorize the release of my medical records to any doctor, employer/employer representative, potential employer, insurance company(s), Voc. Rehab, Rehab nurse(s) all information they may request associated with my medical care. I also request that you release my medical records to the physicians of Acadiana Center.

I have been presented with a copy of this provider's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice and will list any restriction(s) concerning my personal medical information: List any restriction(s) here______________________________

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

I, or my parent/guardian, have read the above statements about the inactivated influenza vaccine and have had the opportunity to ask questions. I/We understand the possible benefits and risks of the vaccination and request to receive the following vaccine at this time:

Fluzone Lot #:______________ Exp: ________ (90686) **Fluzone High** Lot #:______________ Exp: ________ (90662)

☐ Patient ☐ Parent ☐ Guardian Signature/Date ______________________________

Patient/Guardian Printed Name ______________________________

Witness/Administered by ______________________________ Deltoid Side ☐ Right ☐ Left

Date/Time of Immunization ______________________________ ☐ Vaccine Information Statement Given