MARGARET MARY HEALTH

Occupational Health & Wellness Center
1051 State Road 229 N. • Batesville, IN 47006
Phone: 812.932.5105

ONSITE FLU VACCINE CONSENT

Legal Name: _____ Date of Birth: _____ Gender: ❒ Male ❒ Female

Home/Cell Phone Number: _____ E-mail: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Date of Birth: _____

Relationship: _____ Home/Cell Phone Number: _____

School/Employer: _____ Grade: _____ Primary Care Doctor: _____

1. Is this the first time you have ever received the flu vaccine?	❒ No	❒ Yes	
2. Have you ever had a severe, life-threatening allergic reaction to a previous flu vaccine?	❒ No	❒ Yes	❒ N/A
3. Do you have a severe, life-threatening allergy to eggs?	❒ No	❒ Yes	
4. Have you ever had Guillain-Barre syndrome *(A rare nerve disorder causing paralysis)*?	❒ No	❒ Yes	

Insurance: Please contact your insurance company to verify eligibility, coverage and location limitations. Some insurance companies will not cover vaccines administered in the school setting. Immunizations are billed as 'preventative' and may be covered under the wellness category of your insurance plan. Our provider is Lynn Tyrer, PA-C. The insurance company makes the final determination of your eligibility and coverage.

5. Select One:

❒ **No Health Insurance.**
❒ **Insurance Does Not Cover Vaccines.**
❒ **Medicaid.** Charges will be submitted to Medicaid. ***A copy of both sides of insurance card is required to be sent with this form.***
❒ **Insurance Covers Vaccines.** Charges submitted to insurance. ***Complete Guarantor's Information section below. A copy of both sides of insurance card is required to be sent with this form.***

Guarantor's Information (Person carrying insurance):

Legal Name: _____ Social Security Number: _____

Date of Birth: _____ Relationship to Patient: _____

Home/Cell Phone Number: _____ E-mail: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Employer: _____ ❒ Full Time ❒ Part Time

If Guarantor works for school system (SISIC), which school? _____

Acknowledgment and Signature: By my signature below, I represent I am the patient or I am the patient's legal representative and the guarantor of the patient's account pursuant to the financial acknowledgement described above. I represent I have fully read and understand each page of this five (5) page Patient Consent and Conditions of Treatment document, and I agree to be bound by its terms. I acknowledge all of my questions regarding this consent document have been answered to my full and complete satisfaction. I understand I have the right to revoke this consent at any time, except to the extent MMH or practitioners have acted in reliance on it.

The Patient Consent and Conditions of Treatment can be found at mmhealth.org/privacy-policy/
Vaccine Information Sheets can be found at cdc.gov/vaccines/hcp/vis/

Patient/Legal Representative Signature: _____ Today's Date: _____

Printed Name: _____ Relationship to Patient: _____

CONSENTS