MARGARET MARY HEALTH

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

ONSITE FLU VACCINE CONSENT

Patient First Name: _____ Patient Last Name: _____ Date of Birth: _____
Gender: ❒ Male ❒ Female Primary Care Doctor: _____
Home/Cell Phone Number: _____ E-mail: _____
Home Address: _____ City: _____ State: _____ Zip Code: _____
Please select one: ❒ Employee Place of Employment: _____
❒ Student School: _____ Grade: _____

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? ❒ N/A ❒ No ❒ Yes
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

Emergency Contact Information:
First Name: _____ Last Name: _____ Date of Birth: _____
Relationship: _____ Home/Cell Phone Number: _____

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 Michael Parker, DO. The insurance company makes the final determination of your eligibility and coverage.

Select One:
❒ **No Health Insurance.**
❒ **Insurance Does Not Cover Vaccines.**
❒ **Medicaid.** Charges will be submitted to Medicaid.
❒ **Insurance Covers Vaccines.** Charges submitted to insurance. ***Complete Guarantor's Information section below.***

Name of Insurance Company: _____
Member ID Number: _____ Group Policy Number: _____
Address to Send Claims: _____

Guarantor's Information (Person carrying insurance):
Legal First Name: _____ Legal Last 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 have been reviewed.

Patient/Legal Representative Signature: _____ Today's Date: _____
Printed Name: _____ Relationship to Patient: _____

CONSENTS