

**ERIE CENTER ON HEALTH & AGING**  
**406 Peach Street · Erie · PA · 16507 (814) 459-4132**  
**INFLUENZA IMMUNIZATION CONSENT**

**SCREENING QUESTIONNAIRE FOR INJECTABLE INFLUENZA VACCINE**

- |   |            |           |
|---|------------|-----------|
| 1. Have you read over the Vaccine Information Statement on Influenza?   | <b>YES</b> | <b>NO</b> |
| 2. Do you have a fever today?   | <b>YES</b> | <b>NO</b> |
| 3. Are you allergic to eggs or Thimerosal?  | <b>YES</b> | <b>NO</b> |
| 4. Have you ever had a serious reaction to a vaccine in the past?   | <b>YES</b> | <b>NO</b> |
| 5. Do you have a history of Guillain-Barre' Syndrome? (If so, client should talk to doctor before receiving a flu shot) | <b>YES</b> | <b>NO</b> |

**NAME OF PERSON RECEIVING VACCINE:** \_\_\_\_\_ **BIRTH DATE:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **GENDER:** M F  
Street City State Zip

**PHONE:** \_\_\_\_\_ **SOCIAL SECURITY #:** \_\_\_\_\_ (Of person receiving vaccine)

**FAMILY DOCTOR:** \_\_\_\_\_ **ETHNICITY:** W B H OTHER **EMAIL:** \_\_\_\_\_

**MEDICARE** \_\_\_\_\_ **RAILROAD MEDICARE** \_\_\_\_\_  
Claim number from Medicare card Claim number from Medicare card

**SECURITY BLUE/FREEDOM BLUE** \_\_\_\_\_  
Member ID from ins card Group number

**HEALTH AMERICA/ADVANTRA** \_\_\_\_\_  
Member ID from ins card Group number

**TODAYS OPTIONS, UPMC, AETNA, GATEWAY, UNISON** \_\_\_\_\_  
Member ID from ins card Group number (if applicable)

**HIGHMARK BLUE SHIELD AND OTHER MISC INSURANCES:** \_\_\_\_\_  
Member ID from ins card Group number State(back/card)

\_\_\_\_\_  
Subscriber/employee name Subscriber/employee date/birth Cust service phone#(back/card)

**CONSENT: I authorize payment** for approved Medical Benefits be made on my behalf to the Erie Center on Health & Aging for services furnished me by the physician/supplier. **I consent to the use and/or disclosure of my health information consistent with ECHA Privacy Practice Policies** of which a copy has been made available to me. I have read, or had explained, the above information. I hereby release ECHA and its agents from any and all claims of damage, loss, or liability arising out of administration of this vaccine. **I consent to be vaccinated or give consent for vaccination for the person named for whom I am legally authorized to give this consent.**

**Signature of Responsible Party:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PLEASE NOTE: YOU ARE RESPONSIBLE FOR PAYMENT IF YOUR INSURANCE DOES NOT PAY.**  
 On your explanation of benefits, Dr Gary Pasqualicchio, Medical Director, will be listed as the Medical Provider.

**CLINIC SITE:** \_\_\_\_\_ **VACCINE LOT#:** \_\_\_\_\_ **VACCINE EXP:** \_\_\_\_\_  
**NURSE SIGNATURE:** \_\_\_\_\_ **INJECTION SITE:** \_\_\_\_\_