

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

**SCREENING QUESTIONNAIRE FOR INJECTABLE INFLUENZA VACCINE**

- |   |            |           |
|---|------------|-----------|
| 1. Has the Vaccine Information Statement on Influenza been made available to you?                                       | <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 DR:** \_\_\_\_\_ **ETHNIC:** W B H OTHER **EMAIL:** \_\_\_\_\_

**MEDICARE/RAILROAD MC** \_\_\_\_\_ (Claim number from Medicare card)

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

**HIGHMARK BLUE SHIELD** \_\_\_\_\_  
 Member ID from ins card (WITH ALPHA PREFIX) Group number STATE

Subscriber/Employee Name (If NOT Patient)	Subscr/Empl Date/Birth (If NOT Patient)	Customer service # from back of ins card
<b>AETNA:</b>	Member ID# _____	Group # _____
<b>CIGNA:</b>	Member ID# _____	Group # _____
<b>GATEWAY:</b>	Member ID# _____	Group # _____
<b>HEALTH AMERICA/ADVANTRA:</b>	Member ID# _____	Group # _____
<b>SECURE HORIZONS:</b>	Member ID# _____	Group # _____
<b>UNISON/UHC:</b>	Member ID# _____	Group # _____
<b>UPMC:</b>	Member ID# _____	Group # _____
<b>OTHER MISC INS NAME:</b> _____	Member ID# _____	Gr# _____
(CUSTOMER SERVICE PHONE# OF OTHER MISC INS) _____		

**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:** \_\_\_\_\_  
**AMOUNT PAID:** CASH \_\_\_\_\_ CHECK \_\_\_\_\_ CHECK# \_\_\_\_\_