Wellness2000, Inc.
Corporate Wellness • Health Risk Management • Employee Assistance

INFORMED CONSENT FOR VACCINATION

I request the checked vaccine be given to me or the person named below for whom I am authorized to sign. I have been given and have read the Center for Disease Control information for each vaccine, and I understand the benefits, side effects, and risks of the vaccine as described. I release and hold harmless Wellness 2000 Inc. private companies, and community clinics from all risks and damages related to this flu vaccination that is provided to me voluntarily. I understand that I am responsible if payment is denied by my insurance carrier.

PLEASE PRINT

_____ / / /
Last Name First MI DOB: M / D / Y Sex/Gender

_____
Mailing Address City State Zip

(_____) _____ Employer: _____
Phone Number

X _____ _____
Signature of Person to Receive Vaccine (or Parent/Guardian) **Date**

Influenza (Flu): $ _____ **Email:** _____

PLEASE SELECT PAYMENT METHOD

☐ Cash ☐ Check: Ck #:_____ ☐ Visa/MC # _____ Exp. Date: _____

Provide copy of insurance card(s) **or** fill in:
Insurance Carrier: _____ Insurance ID# _____ Group #_____
Deductible and/or Coinsurance payments may apply

Please check (☑) if the person receiving immunization:

☐ Has had flu vaccination in past years with no adverse reactions.
- ☐ Has a severe allergy to eggs.
- ☐ Has ever had a serious allergic reaction or other problem after getting a vaccine.
- ☐ Is currently pregnant or planning pregnancy within 3 months.
- ☐ Has a history of Guillain-Barre Syndrome.
- ☐ Never has had this vaccine before (wait 10 minutes after injection).

Result: ☐ No adverse reaction ☐ Reaction (document on back) ☐ Left without checking back

SERVICES ADMINISTERED:

☐ **Aflura Flu** CPT 90688
Manufacturer: Seqirus Lot #
Exp. Site: R L Deltoid

☐ **Fluad High Dose Flu** CPT 90964
Manufacturer: Seqirus Lot #
Exp. Site: R L Deltoid

RN:_____ Date:____/____/ 2023

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