2024-2025 VACCINATION CONSENT FORM

I, _____, consent to the administration of the Flu Vaccine. I am aware that some people experience pain at the site of injection, and some may even experience fever. I testify that I have none of the conditions listed below:

1. A severe reaction to the Flu shot in the past.
2. A history of Guillian-Barre Syndrome (GBS) in the weeks after getting previous Flu shots.
3. Have an allergy to eggs.

Patient Name_____ Date of Birth_____

Address_____Phone#_____

City_____State_____Zip Code _____

Payment: Cash or Check Insurance: Yes or No

Person who holds insurance (circle one): Self/ Spouse/ Parent
Name of insured (if not self):_____ Date of Birth_____
Member ID _____ Group_____

I agree to assign the payment for this vaccination and the administration to IN & OUT CLINIC, PA. I authorize the release of information to my insurance carrier for the payment of this claim as well as to any health care provider that has a direct interest in my health care. I have provided my insurance card and photo identification to verify my coverage and agreement of this policy. If my insurance carrier denies this claim, I will be held liable for the payment. A photocopy is valid until I provide written non-authorization to IN & OUT CLINIC, PA.

Signature _____
Date:_____ Self or Guardian (circle one)

To Be Completed by Person Administering Flu Vaccine: Vaccination Season Dates: 2024-2025

- 6yr-64yr Flucel Vac by Seqirus Lot # 388529 Exp: June 30 2025
- 65yr FluAD® Adjuvanted Quadrivalent by Seqirus Lot #388476 Exp: May 13 2025

Site of Injection: Right or Left

Administered by:_____ Injection Date:_____