

## FLU VACCINE CONSENT FORM

Patient Name \_\_\_\_\_

Please print

Address: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Have you ever had a **serious allergic reaction** to eggs? Yes \_\_\_\_ No \_\_\_\_

Have you ever had a **serious allergic reaction** to the  
Flu vaccine? Yes \_\_\_\_ No \_\_\_\_

Do you have a history of Guillain-Barre' Syndrome Yes \_\_\_\_ No \_\_\_\_

**I have read or have had explained to me the information regarding the influenza vaccine. I understand the benefits and risks of this immunization. I hereby release the physicians at Rocky Mountain Family Practice and their office staff from any and all liability arising out of the use of this vaccine.**

\_\_\_\_\_ I understand that Rocky Mountain Family Practice will attempt to bill my insurance company for the administration of the flu vaccine. I authorize the release of any medical or other information necessary to process this claim. I also request payment of insurance or government benefits to this office. I understand that this vaccine may go through a separate billing service and I will be responsible for the balance.

\_\_\_\_\_ I choose to pay privately for the flu vaccine. I understand that Rocky Mountain Family Practice will not be billing my insurance company for this. The cost for the regular flu shot is \$35.00 and the cost for a High Dose flu shot is \$60.00

Signature \_\_\_\_\_

Date \_\_\_\_\_

### FLUZONE

Manufacturer: Sanofi-Pasteur

LA

RA

LL

RL

**FLUBLOK (18 yrs. and older)**

**HIGH DOSE \$60.00 (65 yrs. & older)**