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 $45.00 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)