Washington Township Medical Foundation
Part of Washington Hospital Healthcare System

Address: 2500 W. Mowry Ave., Fremont, CA 94538

Name:
MRN:
DOB:
AGE:

FLU SHOT CONSENT FORM

SPECIAL PRECAUTIONS – Children under six months of age and persons with fever should not receive this vaccine. Pregnant women are recommended to get a flu shot but only the preservative free. Individuals who have received another vaccine within the past 14 days should see their primary physician before receiving this vaccine. If you have a reaction, see your primary physician immediately. If you have any questions, please ask.

1.	Are you sick today with a moderate to severe illness (e.g. fever)?	Yes	No
2.	Do you have serious allergy to eggs or to a component of the vaccine?	Yes	No
3.	Have you ever had a serious reaction to influenza vaccine in the past?	Yes	No
4.	Have you ever been diagnosed with Guillain-Barre' syndrome (a type of temporary severe muscle weakness)?	Yes	No
5.	Are you pregnant? (*for female patients only*)	Yes	No

I have read the above information and have had the opportunity to ask questions. I understand the benefits and risks of the flu vaccination as described in the vaccine information sheet (VIS) given to me. I request that the vaccine be given to me or to the person named below for whom I am authorized to sign. Please sign below on the date the flu vaccination is administered.

_____ _____
Signature of the person to receive the vaccine (or Parent/Guardian) Date

(FOR STAFF USE ONLY)

Allergies:_____Temperature:_____

Lot & Expiration: _____VIS Date: 08/06/2021; provided to patient, parent, or guardian

TIME	MEDICATION	DOSE	RTE.	SITE	NDC #	MFG	STAMP
	Flu Vaccine (Regular) Fluarix Trivalent	0.5 ml	IM	Right or Left Deltoid or Thigh	58160-884-52	GSK	
	Flu Vaccine (High Dose) Fluzone HD QIV	240 mcg / 0.5ml	IM	Right or Left	49281-124-65	Sanofi	

Administered by: _____Date: _____

The Washington Electronic Health Record System

PATIENT REGISTRATION

Today's Date: _____ Home Phone#_____-_____-_____ Cell Phone# ___-_____-_____
Patient's Last Name: _____First:_____ Middle Initial:_____
SS#_____-_____-_____Date of Birth_____/_____/_____□Male or □Female *Status*: □S □M □D □W
Home Address: _____Apartment Number:_____
City: _____State: _____Zip Code:_____ Email
Address:_____

How Did You Hear About Us? □Advertisement □Employer □Friend/Relative □Other: _____

PRIMARY INSURANCE: Subscriber to Insurance: □ Self □ Spouse □ Parent □ Company

Last Name:_____ First:_____ Middle:_____

Relationship to Patient: _____ SS# _____Date of Birth:_____

Insurance Name:_____ Subscriber ID:_____ Group #_____

CONSENT FOR TREATMENT

I consent to the treatment necessary for the above named patient. I authorize the release and/or fax of all my medical records to the referring and family physicians and to my Worker Compensation Carrier Company, if applicable. If lab or x-ray is needed, I authorize access to my medical records through the WeCare electronic medical record. I hereby authorize Washington Hospital Healthcare System (Washington Hospital, Washington Township Medical Foundation, Washington On Wheels, Washington Urgent Care, Washington Outpatient Rehabilitation Center, and Washington Radiation Oncology Center) to obtain my prescription/medication history electronically from multiple sources including pharmacies and physicians outside the practice as medically necessary for my treatment. I authorize WHHS to obtain my prescription/medication history as often as they determine necessary for my proper medical care.

FINANCIAL RESPONSIBILITY

I further authorize and request that insurance payments be made directly to Washington Hospital Healthcare System (Washington Hospital, Washington Township Medical Foundation, Washington On Wheels, Washington Urgent Care, Washington Outpatient Rehabilitation Center, and Washington Radiation Oncology Center). My signature on this form acknowledges that I agree to bear full financial responsibility for all services provided that may not be covered by my insurance for the following reasons; not a covered benefit, not referred or authorized, or determined not to be eligible for coverage with Washington Hospital Healthcare System. I am aware that there is a $25.00 fee for any appointments that I miss and had not contacted the office to cancel. I am aware that I have the right to appeal the insurance company's determination. If a denial is received, I will be responsible for the amount of this bill.

I have been offered a copy of *the Washington Hospital Healthcare System Notice of Privacy Practices*. By signing this Registration Form, I consent to the use and disclosure of my protected health information for the purpose of treatment, payment, and healthcare operations.

I hereby state that the information I listed above is accurate and complete. I acknowledge that I am responsible for notifying WHHS of any changes made to my contact information and/or insurance.

_____ _____

DATE **SIGNATURE OF PATIENT OR RESPONSIBLE PARTY**

_____

PRINTED NAME OF PATIENT OR RESPONSIBLE PARTY