Dignity Health
Chandler Regional Medical Center
CRMC/Community Wellness
1955 W. Frye Rd. Chandler, Az. 85224

ADULT Consent for Influenza (Flu) Vaccine

Appointments at: www. Dignityhealth.org/chanlderimmunizations
Masks are required for entrance.
Please bring a ballpoint pen for personal use.
Only adults with appointments will be permitted into the center. If you had any of these kinds of symptoms in the past 24 hours: Fever, body aches, fatigue, cough, sore throat, shortness of breath, headache, sudden loss of smell or taste, nausea or diarrhea , please delay your visit.

PRINT NAME LEGIBLY

FIRST NAME:_____ **DATE OF BIRTH:**_____
LAST NAME:_____ **MIDDLE NAME:**_____
GENDER/SEX:_____ **AGE:**_____ **PHONE:**_____
ADDRESS:_____ **CITY:**_____ **ZIP:**_____

Please mark which one applies:
_____ I DO NOT have health insurance (Uninsured)
_____ I have health insurance that does NOT pay for the flu vaccine (Under insured)
_____ I have health insurance that covers the flu vaccine.

I have been given a copy and have read or have had explained to me the CDC **"Vaccine Information Sheet" for Influenza (flu) Vaccine dated 8/06/21.** I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the Influenza Vaccine and request that it be given to me. **Signature of person to receive vaccine:**_____

Effective April 14, 2003 the law requires that **Chandler Regional Medical Center** give to a patient a copy of its Notice of Privacy Practices for Health Information. This notice describes how medical information about you may be disclosed and how you can get access to this information. We will give you a copy at the time of first treatment and, if we change our notice, thereafter at the next treatment visit. By signing below, you acknowledge receipt of such as the patient, the patient's personal representative, the patient's authorized agent, or an individual involved in the patient's medical care. I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practices" that explains, when, where and why my confidential health information may be used or shared.

Signature of person to receive vaccine: _____ **Date:**_____

PLEASE ANSWER THE FOLLOWING:

- Do you have a fever or acute infection at the present time? ☐ **YES** ☐ **NO**
- Have you had any of these kinds of symptoms in the past 24 hours? ☐ **YES** ☐ **NO**
  - Fever, body aches, fatigue - cough, sore throat, shortness of breath
  - Headache, sudden loss of smell or taste - Nausea or diarrhea
- Are you allergic to eggs? ☐ **YES** ☐ **NO**
- Have you ever had a serious reaction to a previous dose of the flu vaccine? ☐ **YES** ☐ **NO**
- Do you have a history of Guillain-Barre Syndrome (a neurological disorder)? ☐ **YES** ☐ **NO**

ADMINISTRATIVE USE ONLY

DATE VIS & vaccine given	FUNDING	VACCINE	MANUFACTURER/ LOT#	ROUTE	SITE	REVIEWED AND ADMINISTERED BY
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