LabCorp

INSURANCE CONSENT FORM

Clinic: ______

Insurance Name: ______

Insurance ID No.: ______

First Name: ______ Middle Initial: ______

Last Name: ______

Address: ______

City: ______ State: ______ Zip: ______

Phone: ______ - ______ - ______ Birthdate: MM DD YYYY Age: ______

Sex: (M/F/Undesignated) ______

***Contraindication Questions:* Please check YES or NO for each question.**

Question	YES	NO
1. Have you ever had a severe/anaphylactic (life-threatening) reaction after receiving the influenza vaccine?	☐	☐
2. Are you sick today, exhibiting symptoms other than mild coughing, runny nose and/or diarrhea?	☐	☐
3. Have you ever had a severe/anaphylactic (life-threatening) reaction to any of the components in the influenza vaccine you will be receiving today? (I.E. eggs, egg proteins, thimerosol, latex, gelatin, arginine, formaldehyde, gentamicin, polymyxin B, neomycin, etc.) Anything other than hives?	☐	☐
4. Do you have a history of Guillain-Barré syndrome (muscle weakness and possibly paralysis) within 6 weeks of receipt of receiving an influenza vaccine?	☐	☐
5. Are you pregnant or suspect you are pregnant? If yes, please talk to the nurse before receiving the influenza vaccine.	☐	☐

VACCINE ADVERSE REACTIONS

Because influenza vaccine contains only non-infectious purified viral proteins, it cannot cause influenza. An occasional case of respiratory disease following immunization represents coincidental illnesses unrelated to influenza immunization. Most people who receive the vaccine either have no reaction or only mild reactions. **Mild Problems:** Soreness, redness, or swelling where the shot was given. Hoarseness; sore, red or itchy eyes; cough, fever, aches, headache, itching, and fatigue. If these problems occur, they usually begin soon after the shot and last 1-2 days. **Severe Problems:** Life-threatening allergic reactions from vaccines are very rare. If they do occur, it is usually within a few minutes to a few hours after the shot. The safety of vaccines is always being monitored. For more information, visit: www.cdc.gov/vaccinesafety/Vaccine_Monitoring/Index.html

AREA BELOW TO BE COMPLETED BY THE NURSE

Quadrivalent - Multi-Dose Vial 90688	Quadrivalent - Multi-Dose Vial 90756	Senior Shot 65 years and older Pre-filled syringe 90653	T-Free Pre-filled syringe 90674	Manufacturer
☐ Afluria ☐ Fluzone ☐ L Deltoid ☐ R Deltoid Lot #____________	☐ Flucelvax ☐ L Deltoid ☐ R Deltoid Lot #____________	☐ FluAD ☐ L Deltoid ☐ R Deltoid Lot #____________	☐ Flucelvax ☐ L Deltoid ☐ R Deltoid Lot #____________	☐ Seqirus ☐ Sanofi Pasteur
☐ Dose 0.5 mL	Exp. Date _____________		VIS Version Date _____________	
Nurse's Signature________________________			Date of Service _____________	

CONSENT FOR VACCINE ADMINISTRATION

I have read the adverse reactions section above associated with the vaccine(s) being administered. I have had the opportunity to ask questions about these immunizations and I have been offered a copy of the Vaccine Information Statement (VIS) for the vaccine(s) being administered. I ask that the immunization(s) be given to me or the person named below for whom I am authorized to make this request. For myself, my heirs, executors, personal representatives and assigns, I hereby release LabCorp Employer Services, Inc. ("LES") and the site location where I receive this immunization, and their respective affiliates, subsidiaries, divisions, directors, shareholders, members, managers, contractors, agents and employees, from any and all claims arising out of, in connection with or in any way related to my receipt of this or these immunization(s). LES and the other aforementioned parties shall not at any time or to any extent whatsoever be liable, responsible, or in any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccines described above. I believe the benefits outweigh the risks and I voluntarily consent to receive this or these immunizations assuming full responsibility for any reactions that may result. I understand that I may be asked to remain in the general area for at least 15 minutes after receiving the vaccine and that I should report to LES any immediate adverse reactions I experience during this time. I understand LES will not give me medical advice and that I must seek such advice from my own physician.

If I am not the patient and am signing this Consent Form as the patient's legal guardian, durable power of attorney for healthcare, or qualified healthcare surrogate (as defined by state law) (each a "Patient Representative"), I acknowledge that I have full authority to sign on behalf of the patient and maintain all appropriate appointment/governing documentation (e.g.: Durable Power of Attorney for Healthcare/ Finances, Letters Testamentary/Administration, Guardianship Orders, etc.).

Signature of Patient: ____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge receipt of LabCorp Employer Services, Inc.'s Notice of Privacy Practices, which Notice is incorporated by reference herein and outlines various ways my health information will be collected, used and disclosed, including, without limitation, for purposes related to an Employer-Sponsored Wellness Program, my treatment, payment of services, or healthcare operations.

__________ Initial **I AM A MEMBER OF THE INSURANCE PLAN LISTED ABOVE WHICH IS MY PRIMARY MEDICAL COVERAGE. I ACKNOWLEDGE MY BENEFIT PLAN PROVIDES FULL REIMBURSEMENT TO LABCORP EMPLOYER SERVICES, INC. OR I WILL BE RESPONSIBLE FOR PAYMENT. I have read this form or had it read to me, and I understand its contents.**

DO NOT SHARE
(Check Box)

☐ **Signature of Patient:** ____

Please provide a copy of this form to your physician and/or healthcare provider for your permanent medical records.

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