FLU VACCINATION
65 Years & Older
CONSENT FORM

HS HEALTHY SOLUTIONS, INC.

PARTICIPANT TO COMPLETE - PLEASE PRINT LEGIBLY

Print Name: _____ Sex: ☐M ☐F *Check One* Phone: (_____) _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ / _____ / _____ Age: _____ E-mail Address: _____
MM *DD* *YY* (65 years & older)

PLEASE CHECK YES OR NO FOR EACH QUESTION

	YES	NO
1. **Are you 64 years of age or younger?** (Must be 65+ years of age...If yes, you can NOT receive this flu shot)	☐	☐
2. Are you allergic to eggs, egg proteins or any component of the vaccine?	☐	☐
3. Have you had a previous serious allergic reaction to the flu shot?	☐	☐
4. Do you have a current fever; or moderate or severe illness?	☐	☐
5. Do you have a history of Guillain-Barré Syndrome?	☐	☐

Senior Flu Shot

If you answered "yes" on questions 1-5 above you can NOT receive the 65+ flu vaccine at this time. Consult with your physician.
If you have any questions, ***please ask now before receiving the vaccine.*** *If you experience any significant delayed reactions,* ***SEE YOUR PHYSICIAN.***

PRESENT YOUR INSURANCE CARD AT THE CLINIC - MUST BE PRIMARY **PLEASE CHECK WITH YOUR INSURANCE TO VERIFY COVERAGE**

☐ Aetna ☐ Meritain Health (**No** AdventHealth)
☐ All Savers
☐ Blue Cross & Blue Shield (**NO** Blue High Performance Network - HPN) (**NO** OEG, KWF, CSI)
☐ Cerner - Freedom Network Select
☐ Cigna (**No** HealthSpring Medicare or EPO Connect)
☐ Humana (**No** Humana One, PPOX)
☐ United Healthcare (**No** Medica or Core Plans)
☐ UMR
☐ Aetna Medicare
☐ Blue Medicare Advantage
☐ Humana Medicare Health Plan
☐ United Healthcare Medicare Solutions
☐ Medicare Part B **MUST BE PRIMARY**
☐ Railroad Medicare Part B **MUST BE PRIMARY**

We do NOT accept Tricare, Medicaid or ACA Exchange Health Insurance Marketplace (Blue Cross ACA Marketplace is accepted)

Print Name _____
(**NAME OF PERSON RECEIVING VACCINE** - EXACTLY AS LISTED WITH INSURANCE COMPANY)

Member ID # _____ _____
(REQUIRED FOR ALL INSURANCES LISTED ABOVE) (SUFFIX)

For Healthy Solutions Staff ONLY

☐ Cash
☐ Check # _____
Amount Paid $_____
☐ Employer Paid
☐ Healthy Solutions Coupon

I have been offered a copy of the "Vaccine Information Statement" for the vaccine(s) I receive today. I have read the information about the influenza vaccine and I have had a chance to ask questions. I understand the benefits and risks of the influenza vaccination and request that the vaccine be given to me or the person named above for whom I am authorized to sign. I agree that Healthy Solutions, Inc. is not responsible or liable if I contract influenza, other respiratory diseases, or suffer any other adverse reaction following administration of the influenza vaccine. This vaccination is being given to me at my request. As a condition of receiving the vaccine, I, myself, my heirs and executors hereby waive any right I may have to make a claim against Healthy Solutions, Inc. and the sponsoring organization, their affiliates, divisions, subsidiaries, officers, directors, advisory boards, employees, and contractors from any and all claims arising out of, in connection with, or in any way related to my receiving the influenza vaccine. I authorize Healthy Solutions, Inc. to furnish information to and receive payment from insurance companies for services provided me. I understand that these records may be protected by Federal Regulations and have been offered Healthy Solutions, Inc.'s Notice of Privacy Practices. In order to provide program participation Healthy Solutions, Inc. may provide my name to the sponsoring organization or its designated representative. I agree that Healthy Solutions, Inc., its agents and employees, are not liable if individuals or companies to whom they release information disclose the information without my consent. **I AGREE TO WAIT IN THE AREA FOR 15 MINUTES AFTER RECEIVING THE VACCINATION(S).**

The acceptance of your health insurance information does not guarantee coverage or payment by your insurance company.
I fully understand that I will be responsible for charges if insurance or Medicare does not pay.

Participant Signature_____ Date:_____
(65 years of age and older)

Manufacturer	Lot #	Exp. Date	Injection Site	Vaccine	Nurse Signature
❑Seqirus .5ml ❑Sanofi .7ml			❑Right Deltoid ❑Left Deltoid	☒ Prefilled Syringe	