MANNING REGIONAL HEALTHCARE CENTER

An Affiliate of MERCYONE

Online Vaccine Consent & Waiver

Date of Birth: _____ Age: _____

First Name: _____ Last Name: _____

Address: _____City: _____ State: _____ Zip: _____

Circle requested Vaccine:

☐ QIV Fluzone (6months-64yrs) ☐ High Dose Fluzone (> 65 yrs) ☐ Flublok (over 18 years)

Location of Vaccination: ☐ MRHC ☐ Other location _____

SCREENING QUESTIONNAIRE:	YES	NO
1. Do you have allergies to latex, eggs or thimerosal (a preservative)?	☐	☐
2. Do you have moderate to severe acute illness today, with a fever?	☐	☐
3. Have you ever had a serious allergic reaction to the influenza vaccine?	☐	☐
4. Have you ever been in a coma or had prolonged seizures, not attributable to an identifiable cause within 7 days of administration of a vaccine?	☐	☐
5. Have you had Guillian Barre' Syndrome (a problem with your nervous system)?	☐	☐
6. Do you have uncontrolled epilepsy or a brain problem?	☐	☐
7. Have you had progressive neurological disorder, such as uncontrolled epilepsy?	☐	☐
8. Have you had any other vaccines in the past 4 weeks?	☐	☐
9. Are you pregnant?	☐	☐
10. Do you have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐

CONSENT: I have read or have had explained the Vaccine Information Sheet (VIS) about the above mentioned vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and request that the above-mentioned vaccine to be given to me. I received a copy of the Vaccine Information Sheet.

I voluntarily consent and request that MRHC _____submit/_____not submit the claim for this service to my health insurance provider.

I understand that full payment will be required now or after submission to health insurance provider.

Signature of person receiving the vaccine/patient representative:

_____Date_____

For Clinic Use Only

Manufacturer	Exp. Date	Dose	Lot#	Site	Signature of Nurse giving shot

Amount Paid $_____ Form of Payment: _____

_____Entered into IRIS _____Copy of vaccine information given to patient.

(initials)