**\_\_\_\_Flu (Influenza) Vaccination (**Answer questions 1-6 if requesting Influenza Vaccination) **Check Answer**

1. **Has the person receiving the vaccination ever had a Flu shot? 🞎 YES 🞎 NO**
2. **Is the person receiving the vaccination allergic to eggs or egg/chicken products? 🞎 YES 🞎 NO**
3. **Is the person receiving the vaccination sensitive to Thimerosal,**

**an antiseptic and germ killer (commonly used in eye contact lenses solution)? 🞎 YES 🞎 NO**

1. **Is the person receiving the vaccination moderately or severely ill? 🞎 YES 🞎 NO**
2. **Does the person receiving the vaccination have a history of Guillain-Barre Syndrome,**

 **or any other neurological disorder? 🞎 YES 🞎 NO**

**6. Is the person currently taking steroids? 🞎 YES 🞎 NO**

**\_\_\_\_Vitamin B12**

 **Do you have a known sensitivity to cobalt or early Leber’s disease (hereditary optic nerve atrophy)? 🞎 YES 🞎 NO**

**\_\_\_\_\_ Lipo/Fat Burner**

 **Do you have kidney disease?** **🞎 YES 🞎 NO**

##

## \_\_\_\_\_ Do you want to receive emails for future B12/Lipo clinics? 🞎 YES 🞎 NO

**\_\_\_\_\_FEMALES: ARE YOU PREGNANT OR NURSING? \_\_\_\_\_\_\_\_ 🞎 YES 🞎 NO**

###

### You Must Remain in the Area For 15 Minutes After Receiving Your Vaccination!

# I have read the information provided regarding the requested injection, and I have had a chance to ask questions. I understand the benefits and risks and request that the injection be given to myself or to the person named below for whom I am authorized to make this request. I assume full responsibility for any reactions that may result. And will not hold Independent Paramedical Services, Inc. (DBA Mobile Medicals) or any physician associate with Independent Paramedical Service, Inc. responsible.

#

# Name (Please Print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Male 🞎 Female

##

# Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Home Mailing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#  Street City State Zip

**Place of Employmen**t**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Signature of Person receiving vaccine, or Parent/Guardian if under age 18 Date**

## Complete if you have BCBS or Medicare Insurance Plan

Primary Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member Id \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the release of any medical or other information necessary to process the claim. I also request payment of benefits to the party who accepts assignment.

# X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##  Signature of Person receiving vaccine, or Parent/Guardian if under age 18 Date

## This Section (Below) For Clinic Use Only

 **Lipo**

Manufacturer

Empower

Lot#

Exp.

**Site: \_LD RD**

#####  B12

Manufacturer

Empower

Lot #

Exp.

**SITE: LD RD**

## Tdap

Manufacturer

Lot #

Exp.

**SITE: LD RD\_**

**Influenza**

Manufacturer

 Lot #

Exp.

 **LD RD**

##

 Nurse Signature Vaccination Date

## Payment Method: (Circle) Cash Check Card Insurance Company

## Payment Amount $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##  Flu PF HD Mist Tdap B12 Lipo