GetA*FluShot*.com

A Professional Health Care, LLC Company, Established 1989
Community Immunization Provider since 1991

# WA State Employee Insurance Claim Form and Consent Influenza Immunization

Check Primary insurance plan: ☐ Kaiser ☐ Medicare Part B ☐ Uniform Medical Plan
☐ ISHIP (Student Health Insurance Plan) ☐ GAIP (Graduate Appointee Insurance Program)

Washington Primary Insurance ID #

***Last Name***

***First Name***

***Your Street Address where you receive your insurance paperwork (not your email address***

***City*** ***State*** ***ZIP Code***

**Telephone (000-000-0000)** ***Date of Birth(Month/Day/Year)*** ***Gender***

☐ Male ☐ Female ☐ Not Identified

Have you ever had a flu vaccination before? ☐ Yes ☐ No ☐ Unsure
Have you ever had a severe reaction to a flu shot? ☐ Yes ☐ No
Do you have a history of Guillain-Barre Syndrome? ☐ Yes ☐ No
Are you feeling sick today? ☐ Yes ☐ No

Are you allergic to a component of the vaccine? ☐ Yes ☐ No
If female, are you pregnant ☐ Yes ☐ No

I have read the adverse reactions associated with the influenza vaccine. A copy of the vaccine manufacturer's drug information sheet is available on request. 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 GetaFluShot (GAFS), corporation, school, school district, physician and/or medical director and their respective affiliates, subsidiaries, divisions, directors, 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). GAFS 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 assume full responsibility for any reactions that may result. I agree to remain in the general area for at least 15 minutes after receiving the vaccine.

***Signature of responsible person*** ***Relationship to Insured*** ***Date Signed***

Self ☐ Spouse ☐ Child ☐ ☐☐ / ☐☐ / ☐☐

**Clinic Name** _____

**Date of Vaccination:** _____ VIS 8/15/2019

**Mfg/Lot #:** _____ **Expiration Date:** _____

**Nurse's Initials:** _____ **Site of Injection: L R Deltoid**

*NURSE NOTES*