

Person Receiving The Immunization(s)

Patient First Name	Patient Middle Name or Initial	Patient Last Name	
Patient Email			
Mailing Address			
City		State	Zip Code
Phone Number () -	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate (month, day, year)	

Patient Relationship to Company / Event Sponsor

Employee Contractor Dependent of Employee Retiree Other

Payment Methods (Provide any/all Coverage Available)

EMPLOYER

Employer / Spouse	Employee ID
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INSURANCE

Plan Name		Date of Birth of Covered Individual	
Is this your Primary Coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO	Member ID Number	Group Number	Payer ID# on back of card
If you are not the primary insured, name of the covered individual		Relationship to the insured. <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Address of the covered individual (Street, City, State, Zip)			

PATIENT PAYMENT AT TIME OF SERVICE

Payment required for patients with non-contracted insurance plans or patients that are not fully covered by the contracted event sponsor. Debit or Credit Card only. Once services are provided, no refunds will be issued.

Unless payment is expressly guaranteed by the event sponsor, a credit card is required to pay for denied claims, which cannot be predicted at the time of service, or for non-contracted insurance plans accepted in error.

Authorized Charge Amount \$	Cardholder Name (exactly as shown on Credit/Debit Card)		
Credit/Debit Card Number	Expiration Date	Billing Zip Code	

Precautions & Contraindications - please fill in YES or NO for each question

YES NO

- 1. Is this your first flu vaccination?
- 2. Have you ever had an anaphylactic reaction, such as hives, wheezing, difficulty breathing or circulatory collapse related to latex?
- 3. Have you ever had an anaphylactic reaction, such as hives, wheezing, difficulty breathing or circulatory collapse related to chicken eggs, egg products, neomycin, gelatin or yeast?
- 4. Have you ever had an anaphylactic reaction, such as hives, wheezing, difficulty breathing or circulatory collapse related to thimerosal, which is found as a preservative in contact lens solution and some vaccines?
- 5. Are you sick today, or have you had a fever in the past 48 hours?
- 6. Do you have any history of Guillain-Barre Syndrome or paralysis?
- 7. Have you received a pneumonia vaccination in the last 5 years?
- 8. Are you pregnant or breast feeding?

Patient / Guardian Consent and Signature

I have been (1) provided with a copy of and I have had the opportunity to read the Vaccine Information Statement (VIS) for the vaccine(s) I will receive today;(2) made aware of certain risks that may be associated with the vaccine(s) including the potential for allergic reaction; and (3) offered the opportunity to ask questions, which were answered to my satisfaction. I believe that the benefits outweigh the risks and I assume full responsibility for any reactions that may result. I authorize Passport Health to disclose my health information to my state immunization registry, my physician, my employer and my insurance company. I authorize Passport Health to notify me of future health events, services or products. I hereby acknowledge receipt of Passport Health's Notice of Privacy Practices, which may also be accessed at www.PassportHealthUSA.com. If I am signing this consent on behalf of another individual, I hereby certify that I have the legal right to do so as the person's parent or legal guardian, pursuant to a health care power of attorney, pursuant to a court order, or pursuant to some other legal right to consent to health care for the individual. I agree that the insurer or payer listed above is my PRIMARY MEDICAL coverage and that I am responsible for payment if services are not covered for any reason or are subject to any co-pays, deductibles, coinsurance or prior authorizations

Signature of Patient, Parent or Legal Guardian

Nurse Signature

Services Administered (Nurse Use Only)

Event Number _____ Event Date _____ Nurse ID _____
 Service Administered Quad Quad Preservative Free Tri Tri Preservative Free Pneumonia Other _____

Service 1

Shot Location	<input type="checkbox"/> IM Left <input type="checkbox"/> IM Right
Lot #	
Expiration Date	
Manufacturer	

Service 2

Shot Location	<input type="checkbox"/> IM Left <input type="checkbox"/> IM Right
Lot #	
Expiration Date	
Manufacturer	

Service 3

Shot Location	<input type="checkbox"/> IM Left <input type="checkbox"/> IM Right
Lot #	
Expiration Date	
Manufacturer	