Reset Form

Total Wellness Corporate Health

Patient Number: _____

Consent for Immunization

First Name (Legal) | MI | Last Name

☐ Male ☐ Female

Date of Birth: | Check One Box | Phone Number

Home Address | City | State | Zip

Please check immunization(s) requested:

Flu ☐ **High Dose Flu (65+)** ☐ **TDAP** ☐ **Shingles** ☐ **HEPB** ☐ **B12** ☐

Medical Questions

Have you ever had a reaction to a vaccination? ☐ Yes ☐ No

Have you had a fever in the last 24 hours? ☐ Yes ☐ No

Female: Are you pregnant or breastfeeding? ☐ Yes ☐ No

Are you allergic to eggs? ☐ Yes ☐ No

Do you have Guillain-Barre syndrome? ☐ Yes ☐ No

For B12 Only: Do you have history of gout, lebers disease, kidney or liver disease? ☐ Yes ☐ No

Insurance Information

Primary Insurance Provider | Member ID | Group Policy Number

☐ Male ☐ Female

Policy Holder Name | Gender | Date of Birth | Relationship

Secondary Insurance Provider | Member ID | Group Policy Number

☐ Male ☐ Female

Policy Holder Name | Gender | Date of Birth | Relationship

By signing this document, I have verified that all information provided is correct and I have read the appropriate information regarding the immunization(s) I will receive today. I am aware of any risks or possible side effects that may occur. I understand that Total Wellness will do everything possible to receive reimbursement from my health insurance for vaccination(s) that I received today. In the event that Total Wellness does not receive remimbursement, I acknowledge that I'm responsible for payment to Total Wellness for the vaccination(s).

Signature **Date**

For Staff Use Only

Flu	Lot:	Exp:	Left	Right	Staff Initials	
High Dose Flu (65+)	Lot:	Exp:	Left	Right	Staff Initials	
TDAP	Lot:	Exp:	Left	Right	Staff Initials	
Shingles	Lot:	Exp:	Left	Right	Staff Initials	
HepB	Lot:	Exp:	Left	Right	Staff Initials	
B12	Lot:	Exp:	Left	Right	Staff Initials	

TW staff provided immunizations to patient without difficulty and observed no adverse reaction

Staff Name(Print) **Staff Signature** **Date**