NORTHERN MICHIGAN UNIVERSITY

ADA B. VIELMETTI HEALTH CENTER
1401 Presque Isle Avenue
Marquette, MI 49855-5301
906-227-2355 | FAX: 906-227-2332
nmu.edu/HealthCenter

INFLUENZA IMMUNIZATION CONSENT FORM

Flu Clinic Date: □ **Tuesday, October 13, 2020 (Noon to 4pm) Northern Center**
□ **Tuesday, October 27, 2020 (Noon to 4pm) Northern Center**
□ **Tuesday, November 10, 2020 (Noon to 4pm) Northern Center**

TEMP:_____ *(Will be taken at the event)*
I have been given the opportunity to review the Vaccine Information Statement and ask any questions. I understand the benefits and risks of receiving this vaccination.

Name:_____ Date of Birth:_____
IN#:_____

SIGNATURE:_____

Please check all boxes that apply:

- ☐ No Moderate or severe acute illness with or without fever
- ☐ No serious reaction to eggs, egg protein, gentamicin, gelatin or arginine
- ☐ No serious reaction to neomycin or polymycin
- ☐ No serious reaction to a previous dose of influenza vaccine
- ☐ No history of Guillan-Barre Syndrome
- ☐ NO cough, fever, shortness of breath, loss taste/smell
- ☐ NO close contact to known Positive Covid-19 case in past 14 days
- ☐ NOT awaiting a Covid-19 test result

Payment (Please check the appropriate line)
___University BCBS Insurance ID #: KMU_____
___I have been to the health center, my information is on file *(I understand I will be billed if invalid or outdated)*
___ Medicaid: Vaccinations should be done at the Mqt County Health Dept: See Back of Form
___ Other Insurance (please complete the below section)
___ Cash ____ Check ____ e-bill (30.00 for Flu Shot + inj Fee)

INSURANCE INFO FROM CARD
If you would like us to attempt to bill your insurance company for this charge, please complete the insurance information below: MICHIGAN MEDICAID –See note below*.

Insurance Company Name:_____
Name of Insured:_____
Address of Insured:_____
***Date of Birth of Insured**:_____

Insurance ID# _____
Insurance Group #: _____

* **Michigan Medicaid** should get immunizations at the Marquette County Health Dept. or VFC Clinic. If requested to be done by the NMU Health Center, you will be responsible for any cost not covered. Please sign below that you understand and accept this. Cost of Flu Shot $30.00 + inj fee.

_____ _____
Signature Date