CONSENT AND RELEASE FOR INFLUENZA VACCINATION

(Please read vaccine information statement)

I have read the information on the Vaccine Information Statement and have had an opportunity to ask questions. I understand the benefits and risks of the flu vaccination as described. I request that the vaccine be given to me or the person named below for who I am authorized to sign.

I understand that the vaccination is being given by Saad Healthcare Services, Inc. its subsidiaries, divisions, affiliates, officers, directors and employees expressly disclaim any responsibility with respect to the vaccination procedure. My consent is given in light of this information and in consideration of **Saad Healthcare Services, Inc.** giving the influenza vaccination. I, for myself, my heirs, executors and assigns hereby agree to release **Saad Healthcare Services, Inc.** its subsidiaries, divisions, affiliates, officers, directors and employees from any and all claims arising out of, in connection with, or in any way related to my receipt of the influenza vaccination.

_____ (Initial) I declare that I am over the age of 18 years old and that I will remain near or about the flu vaccination location for 15 minutes after receiving the flu vaccination.

_____ (Initial) I declare that I am the parent/guardian of the child named below and that he/she is at least 10 years old.

I understand that if at a later date my insurance information presented at the time of administration is other that regular Part B Medicare or otherwise does not cover the price of the flu shot (such as Medicare Part A, Medicare Complete, United Healthcare, Senior's First, Health Springs, BC/BS, or any other HMO Coverage), Saad Healthcare has the right to bill me for the non-covered services.

Information about the recipient of the flu vaccination: PLEASE PRINT

Last Name	**First Name**	**MI**	**Birth Date**	**Age**	**Sex**

Address	**City**	**State**	**Zip Code**

_____ _____

(Signature of Recipient of Flue Vaccination or person Authorized to make request) **(Date Signed)**

Telephone number ( ) _____

Allergies: _____

Physician Name: _____

FOR OFFICE USE ONLY

Clinic Location _____ **Date:** _____ **Lot #:** _____

Given IM, 0.5cc of vaccine: R or L deltoid, other _____ **Nurse Initials:** _____

Medicare # if applicable: Regular - Part B Only _____

Humana Gold Choice (except group # Q5324 _____

Method of payment: Cash _____ Check _____