



**Shaw Family Medical Primary/School-Based Clinic  
FLU/COVID-19 VACCINATIONS CONSENT FORM**

**TO BE COMPLETED BY ADULT PATIENT/PARENT OR LEGAL GUARDIAN (Please Print)**

|  |  |      |  |   |  |         |    |
|--|--|------|--|---|--|---------|----|
| Patient Name:  |  |      |  | MALE:                                       |  | FEMALE: |    |
| DOB:   |  | SSN: |  |   |  |         |    |
| Address:   |  |      |  | City/State/Zip:                             |  |         |    |
| Home Phone:  |  |      |  | Work Phone:                                 |  |         |    |
| Cell Phone:  |  |      |  | Consent to text regarding appointments: YES |  |         | NO |
| School:  |  |      |  | Grade:                                      |  |         |    |
| <b>Emergency Contact Name and Phone Numbers</b>  |  |      |  |   |  |         |    |
| <b>1.</b>  |  |      |  | <b>2.</b>                                   |  |         |    |
| Preferred Pharmacy:  |  |      |  |   |  |         |    |
| Parent/Guardian's Name:  |  |      |  |   |  |         |    |
| Parent's email address:  |  |      |  |   |  |         |    |
| <b>Insurance Information</b>   |  |      |  |   |  |         |    |
| Insurance/Medicaid Number:   |  |      |  |   |  |         |    |
| <b>Private Insurance Information</b>   |  |      |  |   |  |         |    |
| Policy Holder:   |  |      |  | Relationship to child:                      |  |         |    |
| Group Number:  |  |      |  | Policy Number:                              |  |         |    |
| <b>Additional Information</b>  |  |      |  |   |  |         |    |
| <p>1. Is the patient allergic to Eggs?</p> <p>2. Did the patient answer YES to any of the pre-covid-19 vaccine questions? Please describe:</p> |  |      |  |   |  |         |    |

**NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED. YOU MAY ALSO HAVE ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

We are also required by law to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices with respect to your medical information. We are required by law to abide by the terms of this notice.

If you have any objections to this form please speak to the HIPPA Compliance officer for SHAW FAMILY MEDICAL, (the providers). A copy of the privacy policy can be found on each provider’s website.

**\*Signature:** \_\_\_\_\_

**SHAW FAMILY MEDICAL**

I authorize **SHAW FAMILY MEDICAL** to perform the following procedures;

- Influenza vaccination (to be given during the peak influenza season)            **YES**      **NO**  
     Circle Yes or No
- Covid-19 Vaccination      **YES**      **NO**  
     Circle Yes or No
- Other Vaccination: \_\_\_\_\_      **YES**      **NO**  
     Circle Yes or No

*I also authorize **SHAW FAMILY MEDICAL** to file and bill my/my child’s Insurance/Medicaid for Medical services rendered.*

**\*Signature of Patient/Parent/Legal Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**\*Printed Name of Patient/Parent/Legal Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_