Insurance Claim Form: Covid-19 Immunization Consent

GetA*FluShot*.com
A PROFESSIONAL HEALTH CARE LLC COMPANY, ESTABLISHED 1999 • COMMUNITY IMMUNIZATION PROVIDER SINCE 1991
SERVING OREGON & WASHINGTON STATES

If you have experienced extreme reaction, have allergies, or carry an EPI pen, you will to obtain your Covid vaccine at a medical facility for your safety.

Regence ☐	Providence ☐	Moda ☐	Kaiser ☐	Premera ☐	Lifewise ☐	Aetna ☐
Humana ☐	Medicare ☐	Pacific Source ☐	OR Medicaid ☐	United Health ☐	UMR ☐	Uniform Medical ☐

First Health Group # _____ ☐ Collective Health Group # _____ ☐

Other Insurance not listed above: _____

Primary Insurance ID

Secondary Insurance ID

Last Name

First Name

Your Street (or Mailing) Address where you receive your insurance paperwork

City State Zip Code

Telephone (000-000-0000) Date of Birth (Month-Day-Year)

Gender		
M	F	NI
☐	☐	☐

Email Address: _____

Do you have a fever?	Yes ☐ No ☐	If female, are you pregnant or plan to become pregnant	Yes ☐ No ☐
Do you have any allergies?	Yes ☐ No ☐	If female, are you breastfeeding	Yes ☐ No ☐
Do you have a bleeding disorder or on blood thinners	Yes ☐ No ☐	Have you had a severe reaction after a previous dose of Covid Vaccine or to any ingredients in the vaccine	Yes ☐ No ☐
Are you immunocompromised or on a medicine that affects your immune system	Yes ☐ No ☐		
Have you received another dose of Covid Vaccine	Yes ☐ No ☐	Date of Last Dose (mm-dd-yyyy)	

I have read about possible adverse reactions to the Covid vaccine. A copy of the Covid-19 Vaccine Information Sheet (VIS), and additional copies have been made available to me. I have had the chance to ask questions, and all have been answered to my satisfaction. I request that the vaccine be given to me or the person I am authorized to represent, and I accept the benefits and risks. I release GetaFluShot (GAFS), its affiliates, and related parties from any claims related to this immunization. Per the No Surprise Billing Act, GetAFluShot.com follows Medicare pricing guidelines. I agree to pay for the vaccine and its administration if I do not have active or accepted insurance, and I consent to being contacted if more information is needed to process my consent or reimbursement.

Signature of responsible person	Relationship to Insured	Date Signed
X	☐ Self ☐ Spouse ☐ Child	

Nurse Initials_____ Deltoid Injection Site L R

Vaccine Information Sheet date: 1/31/2025

Affix Location Label Here

Affix Mfg/Lot Number & Expiration Label Here

Nurse Notes

Rev: 6/2026