PicMED Weight & Wellness

Tulsa, OK	11014 E. 51st St.	918.438.5005
Oklahoma City, OK	6900 N. May Ave.	405.286.4747
Norman, OK	1015 24th Avenue	405.310.4050

Flu

Flu Vaccine Consent Form

Patient Information and Consent

PLEASE PRINT CLEARLY

Last Name: *		First Name: *		Middle Initial: *	
Contact Phone:		Employer:			
Birth Date: *		Gender: *	◯ Male ◯ Female		

Insurance Only

We only accept the following insurance	◯ Aetna ◯ Blue Cross ◯ Cigna ◯ United Health ◯ UMR	Member ID #:		Group #:		Relationship to insured:	☐ Self ☐ Spouse ☐ Child
		Home Address:		City, State, Zip			
		☐ I agree that, if for any reason my insurance claim is denied, I will still be held responsible for payment in full to PicMed for services rendered.		Initials:			

Flu Vaccine Questionnaire

Have you ever had an allergic reaction to flu vaccine?	◯ Yes	◯ No
Are you allergic to eggs, or egg products?	◯ Yes	◯ No
Do you have a history of Guillain-Barre Syndrome?	◯ Yes	◯ No
Are you allergic to latex?	◯ Yes	◯ No
Do you feel ill today or do you have a fever?	◯ Yes	◯ No
If you are female, are you pregnant?	◯ Yes	◯ No

I hereby certify that the foregoing history is true and complete to the best of my knowledge and have had an opportunity to ask questions that were answered to my satisfaction and do wish to receive this procedure fully understanding the risks and the benefits. Risk and possible side effects could include soreness, fever, aching for one or two days. As with most drugs or vaccines, there is possibility of allergic reaction or more serious reactions, even death, could occur. I hereby consent to the administration of the vaccine.

Furthermore, I hereby release and forever discharge for myself, my heirs, executors, administrators and assignees, PicMed Wellness and their employees, owners and representatives, as well as the company sponsoring this event and their agents, representatives, employees, successors, assignees, governing bodies, and advisory committees from any and all claims, demands, actions and causes of action, which may result from participation in this program.

Your personal information and results shall be held strictly confidential. I understand PicMed Wellness will not bill insurance; however, forms/receipts are available for reimbursement.

Signature:		Date:	

FOR CLINIC USE ONLY

Immunization Given	Mfg.	Lot#	Exp. Date	Injection Site	Administered By Initials	Dose #1	Dose #2
2025/26 Influenza Trivalent - 3 years	Seqirus Afluria			R / L Deltoid IM R / L Thigh Anterolateral			
2025/26 High Dose Trivalent –65 years +	Seqirus Fluad			R / L Deltoid IM R / L Thigh Anterolateral			

Payment Information

Method	
Employer	❑
Cash	$_____
Check	$_____ #_____
Credit Card	$_____

Credit Card #:		Expiration Date:	CVC Code: (3 digits on back of card)
❑ I hereby authorize **Pic-Med** of Oklahoma to charge my credit card account.		Signature:	