OnSiteCare
Affordable Healthcare at Work

Patient Name_____ DOB_____ Age_____ Phone # (_____)_____

Home Address_____City_____State_____Zip_____ Sex M F

Email_____ Employer_____

Please check one: Is the patient an ☐ Employee ☐ Spouse ☐ Dependent ☐ Other

Insurance Information: Please Circle Plan

Select Health Meritain PEHP UHC/UMR Wellmark BCBS Cigna Altius Aetna No Insurance Other_____.

Policy Holder's Name_____ DOB _____Policy #_____

Yes	No	
○	●	**Is this a first in a lifetime flu shot?**
○	●	**Has there been a serious problem with a previous flu shot?**
○	●	**Are you ill with a fever, chills, fatigue, muscle or body aches, headache, congestion, runny nose, sore throat, cough, shortness of breath, loss of taste or smell, nausea or vomiting, diarrhea today?**
○	●	**Is there an allergy to eggs, gentamicin, gelatin, or arginine?**
○	●	**Is there a history of Guillain-Barré Syndrome?**

I have been given and read or have had explained to me, the information in the Vaccine Information Statement(s), vaccine and/or medication information sheets about the vaccine(s) and/or medication and the related disease below. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines and/or medication. I request the vaccine(s) and/or medication be given to the person named above for whom I am authorized to make this request. Physician signature on file: Anthony Musci. NPI # 1205853173 Place of service code- 11 OnSite Care Clinics 560 S. 300 E. Suite 275 SLC, UT 84111

Vaccine	Patient Initials	Date	VIS Date	Dose/RT	ICD-10	Site	Lot #	Exp. Date	MA Signature	Follow up due
Influenza 36 months to adult CPT 90686-90471			08/15/19	0.5 cc IM	Z23		Place Label	06/30/21		
Influenza 6 -35 Months CPT 90687-90471			08/15/19	0.25 cc IM	Z23		Place Label	06/30/21		

Signature of Patient/Guardian_____ Date _____

Revised Onsite Care 9/23/2020