2020-21 Visiting Nurse Association Immunization Consent Form

Section 1 – PLEASE PRINT LEGIBLY (information for person being immunized).

LEGAL Name (Last, First, MI) | **Date of Birth** | **Age** | **Gender** ☐M ☐F

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

Phone | **Email Address**

Section 2 - INSURANCE INFORMATION (ALL must be the Primary Insurance Coverage) Complete PARTS A and B.

PART A: Check primary insurance:

☐ Medicare or RR Medicare*
*NO Medicare Advantage Plans accepted!

☐ BCBS of NE

☐ Aetna

PART B: Complete insurance information:

Policy Holders Name_____ DOB _____ ☐Male ☐Female

Policy ID Number_____ Policy Holder Last 4 of SSN_____

Relationship to insurance holder: ☐Self ☐Child ☐Spouse ☐Partner

Section 3 - Please select Yes or No in response to the following questions.

1. Sick or have a fever? ..... Yes☐ No☐
2. Have an allergy to eggs, latex, aluminum, yeast, thimerosal, Neomycin, Gentamicin*, Arginine*, gelatin*?... Yes☐ No☐
3. Had a serious reaction to a previous dose of any vaccine?..... Yes☐ No☐
4. Have any neurological problems, seizures, central nervous system disorders, Guillain-Barre'?..... Yes☐ No☐
5. Pregnant or planning to be in the next 4 weeks?..... Yes☐ No☐

***Answer questions 6-9 only if receiving FluMist:**

*6. Have any chronic health problems, asthma, diabetes, heart or lung disease? ..... Yes☐ No☐
*7. Have cancer, AIDS, other immune problems, or live with someone who does? ..... Yes☐ No☐
*8. Take cortisone, prednisone, any other steroids, chemotherapy or get radiation therapy? ..... Yes☐ No☐
*9. Had any other vaccines in the last 4 weeks? ..... Yes☐ No☐

CONSENT: I acknowledge that the medical information provided above is (electronic copy of the Notice of Privacy Practices and Vaccine Information Stat or the person named for whom I am authorized to make this request. I under monitored for the possibility of reaction. I authorize the VNA to use this signature for consent to bill the insurance company/credit card and to authorize payment to the VNA. I understand that I will be responsible for the cost if my insurance does not cover this/these immunization(s). If above client is under 19 years, I attest that I am the child's parent or legal guardian and may provide consent for this/these immunization(s).

Click Here to Print Form then Bring to the Clinic

Individual OR Parent/Guardian Signature: _____ **Date:**_____

Influenza Vaccine/Route/Dose: | ***Site:*** | ***Lot #:***

☐ **Fluarix** – IM/0.5mL (≥6 months) **LD RD**

☐ **Fluzone HD** – IM/0.5mL (≥65 years) **Other:** _____

☐ **FluMist** – IN

☐ **Other** Vaccine:_____ Route: IM Dose: 0.5mL

Vaccine Name/Route/Dose: | ***Site:*** | ***Lot #:***

☐ **Boostrix -** IM/0.5mL (≥ 10 years) **LD RD** **Boostrix Lot#:** _____

☐ **Engerix-B** –IM/1.0mL (≥ 20 years) **LD RD** **Engerix-B Lot#:**_____

☐ **Havrix** –IM/1.0mL (≥ 19 years) **LD RD** **Havrix Lot#:**_____

Nurse Signature:_____ **Date:**_____

☐ Cash
☐ Check#_____
☐ CC
☐ Bill Employer
☐ BCBS of NE
☐ Aetna
☐ Medicare
☐ (Circle one):
VNA Employee/
BM/Volunteer
☐ Voucher