2022-23 Visiting Nurse Association Immunization Consent Form

Print 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
*Blue Advantage not accepted

☐ 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 correct. I have been offered a paper copy or have been able to access an electronic copy of the Notice of Privacy Practices and Vaccine Information Statement, understood the risks/benefits and request that the vaccine be given to me or the person named for whom I am authorized to make this request. I understand that I/the person named, must remain on site for at least 10 minutes to be 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).

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 (2-49 years)		
☐ **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