2023-24 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
*Limited Medicare Advantage Plans accepted!

☐ BCBS of Nebraska

☐ Aetna

PART B: Complete insurance information:

Policy Holders Name_____DOB _____ ☐Male ☐Female

Policy ID Number_____

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, understand 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 it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. On behalf of the person named, the person named heirs and personal representatives, I hereby release and hold harmless Visiting Nurse Association of the Midlands ("VNA"), its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. 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 person named is under 19 years, I attest that I am the child's parent, legal guardian, or legal representative and may provide consent for this/these immunization(s)

Individual OR Parent/Gurardian 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 Insurance
☐ VNA Employee
☐ Board Member
☐ Volunteer
☐ Voucher