2026-27 VISITING NURSE ASSOCIATION IMMUNIZATION CONSENT FORM

PLEASE PRINT LEGIBLY ***CLINIC LOCATION:*** ___________________

Section 1 – Person being immunized

LEGAL NAME (First, MI, Last, Jr, Sr) **DATE OF BIRTH** **AGE** **WEIGHT (lbs.)** **GENDER**

____ M☐ F☐ Other☐

ADDRESS **CITY** **STATE** **ZIP CODE**

____

PHONE **EMAIL ADDRESS** **SS#**

____

I would like to receive the following vaccine(s) (select all that apply):

☐ Flu (Fluarix or Fluzone) ☐ Senior Flu (Fluad) ☐ FluMist ☐ COVID-19 (Pfizer, Comirnaty)
☐ Hepatitis A (Havrix) ☐ Hepatitis B (Engerix-B) ☐ Tdap (Boostrix) ☐ Pneumonia (Capvaxive)

Vaccine Information Statement (VIS) Acknowledgement:

I have received and reviewed the VIS for the vaccines I/dependent will receive: (Initial) __________

Section 2 – Insurance Information – Please include a front/back copy of insurance card(s)

PRIMARY INSURANCE:______________________________Policy ID Number: ____________________Policy Holder DOB:_______

Policy Holder Name: ___________________________________Relationship to Policy Holder:____________________________

SECONDARY INSURANCE:___________________________Policy ID Number: ____________________Policy Holder DOB:_______

Policy Holder Name: ___________________________________Relationship to Policy Holder:____________________________

Section 3 – Please select Yes or No for each question about the person to be vaccinated

All vaccines:

Question	Response
Is the person to be vaccinated sick or have a fever today?	☐Yes ☐No ☐Don't Know
Does the person to be vaccinated have an allergy to food or an ingredient of the vaccine? (examples: eggs, latex, aluminum, yeast, thimerosal, neomycin, gentamicin, arginine, gelatin, polyethylene glycol, polysorbate, bovine protein, polymyxin, phenol) If yes, please list:	☐Yes ☐No ☐Don't Know
Have they ever had a serious reaction to a previous dose of any vaccine?	☐Yes ☐No ☐Don't Know
Has the person to be vaccinated ever felt dizzy or faint before, during, or after a shot?	☐Yes ☐No ☐Don't Know
Have they ever had a seizure disorder for which they are on seizure medication(s), a brain disorder, Guillain-Barré syndrome (a condition that causes paralysis) or other nervous system problem? If yes, please list:	☐Yes ☐No ☐Don't Know
Are they pregnant or planning to be in the next 4 weeks?	☐Yes ☐No ☐Don't Know ☐N/A
Have they had any other vaccines in the last 4 weeks? If yes, please list:	☐Yes ☐No ☐Don't Know
Are they anxious about getting a shot today?	☐Yes ☐No ☐Don't Know ☐N/A

Only answer these questions if receiving the COVID-19 vaccine:

Question	Response
Have they ever been diagnosed with a heart condition (myocarditis or pericarditis) or have they had Multisystem Inflammatory Syndrome (MIS-C) after an infection with the virus that causes COVID-19?	☐Yes ☐No ☐Don't Know
If they are under 65, do they have any underlying conditions that make them high-risk for COVID-19?	☐Yes ☐No ☐Don't Know
Have they ever had a non-severe, immediate (onset less than 4 hours) allergic reaction after administration of a previous dose of one COVID-19 vaccine type? If yes, which one?	☐Yes ☐No ☐Don't Know

Section 3, continued

Only answer these questions if receiving the Flu Mist (Live Vaccine):

Question	Response
Do they have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐Yes ☐No ☐Don't Know
In the past 6 months, have they taken medicines that affect their immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐Yes ☐No ☐Don't Know
Does the person to be vaccinated have a long-term health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease, or metabolic disease (e.g., diabetes)?	☐Yes ☐No ☐Don't Know
If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider told you the child had wheezing or asthma?	☐Yes ☐No ☐Don't Know ☐N/A
Does the person to be vaccinated have a) an open channel between the cerebrospinal fluid (CSF) and the mouth, throat, nose or ear or any other cranial CSF leak, or b) a cochlear implant, or c) an immunocompromising condition due to any cause (e.g., medication, congenital or acquired immunodeficiency, HIV infection, or a missing or non-functioning spleen [e.g., caused by sickle cell disease])?	☐Yes ☐No ☐Don't Know
Is the person to be vaccinated currently taking influenza antiviral medications, or have they taken any within the past 3 weeks?	☐Yes ☐No ☐Don't Know
Is the person to be vaccinated a child or teen age 2 year through 17 years and receiving aspirin- or salicylate-containing medicine?	☐Yes ☐No ☐Don't Know ☐N/A
Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?	☐Yes ☐No ☐Don't Know

Consent: I acknowledge that the medical information provided above is correct. I authorize the provider to administer the vaccines selected above in Section 1. 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 myself or the person named, myself or the person's named heirs and personal representatives, I hereby release and hold harmless Visiting Nurse Health Services, 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 release of any medical information or other information necessary to process an insurance claim or payment. **I understand that I will be responsible for the cost if my insurance/payor 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/Guardian Signature: ______________________________ ***Date:*** _______________

I consent for the person listed in Section 1 to receive the selected vaccines without me being present.
Parent/Guardian Signature:____ **Date:** ____________________

Consent Received: Name of POA/Guardian: _______________________ **Relationship:** _______________________

Consent Obtained by: Name and Title: ___________________________ **Date obtained:** _______________________

FOR OFFICE USE ONLY

Vaccine/Route/Dose:	***Site***	***Lot #:***
☐**Fluarix-** IM/0.5mL (≥ 6 months)	LD RD Other	
☐**Fluzone-** IM/0.5mL (≥ 6 months)	LD RD Other	
☐**Fluad -** IM/0.5mL (≥ 65 years)	LD RD	
☐**FluMist** – IN (2-49 years)		
☐**FluZone HD** – IM/0.5mL (>65 yrs)	LD RD	
☐**COVID-19** – IM/0.3ML (≥ 12 years)	LD RD	
☐**Pneumonia PCV-21** – IM/0.5ML (≥ 50 yrs)	LD RD	
☐**Boostrix-** IM/0.5mL (≥10 years)	LD RD	
☐**Energix-B-** IM/1.0mL (≥20 years)	LD RD	
☐**Havrix–**IM/1.0mL (≥19 yrs)	LD RD	

☐Insurance
☐Bill Employer:____________________
☐Cash/Check/CC
☐Voucher:_______________________
☐Grant: _________________________
☐On-site Clinic Name:______________
☐Homebound ☐VNA Employee
☐Hospice
☐Other:_________________________

*If the insurance provided does not cover the vaccine, the patient will be responsible for the cost.

Nurse Name (PRINT): __________________ ***Nurse Signature:***____________________ ***Date:***______________