☐ Self Pay/Cash/Check
☐ Medicare/Insurance
☐ Child _____
☐ Other _____

INFLUENZA VACCINATION
ASSESSMENT & CONSENT FORM

Yes	No	
☐	☐	Are you under the age of 65?
☐	☐	Are you allergic to eggs, egg products, latex, or thimersol *(found in some eye cosmetics, ear, nose & eye meds)*?
☐	☐	Are you sick with a fever greater than 100 degrees Fahrenheit?
☐	☐	Do you have a history of Guillain-Barre' Syndrome *(a neurological disorder)* or any other neurological disorder?
☐	☐	Do you have a bleeding disorder *(thrombocytopenia, low platelet count)*?
☐	☐	Do you smoke, have asthma or another chronic condition *(such as diabetes)*?
☐	☐	Have you ever had a severe allergic reaction? *(food, medicine, **flu shot**, other)*, i.e. hives, breathing difficulty, shock, requiring emergency medical treatment or within 48 hours of a previous vaccine? If yes, specify

QUESTIONS

If you have any questions about the Influenza Disease or the Influenza Vaccination, please ask the nurse for clarification now or call your doctor before requesting the vaccine. If you have any questions or concerns following the vaccination, please call the MC VNA at 248-967-8755. If you experience any adverse effects from the Influenza Vaccination, please contact your physician and notify the MC VNA (also notify your employer if you received your vaccination at work).

CONSENT AND RELEASE FOR INFLUENZA VACCINE

- I have read the 2014-2015 VIS regarding the Influenza Vaccine. I have had an opportunity to ask questions, and my questions have been answered to my satisfaction. I understand the benefits and risks of the Influenza Vaccination as described. I request that the vaccine be given to me. I understand the vaccination is being provided by MC VNA. **I expressly release MC VNA from any liability resulting from the Influenza Vaccine itself.**
- I agree to remain under observation for at least 15 minutes. Should I leave before that period lapses, I expressly release MC VNA from any liability resulting from any adverse reaction to the vaccine which may occur during that period and thereafter. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense. I understand side effects may include, but are not limited to: soreness at the injection site, fever, fatigue and headache. There is some risk for Guillain-Barre Syndrome. Severe reactions may include anaphylaxis and death.
- In the event a MC VNA employee is exposed to my blood or other body fluids, I agree to have my blood tested for HIV and Hepatitis and have the results released to MC VNA/exposed person, but not to anyone else unless required/authorized by law.
- I acknowledge that I have received written information on MC VNA's "Notice of Privacy Practices" prior to the provision of service, and I have had the opportunity to have my questions answered.
- I wish to have MC VNA bill Medicare/my insurance for the cost of my shot. MC VNA agrees to accept provider payment.
- I acknowledge that I am responsible to reimburse the MC VNA for charges not covered by my insurance.
- I agree to give a copy of this consent form to my employer (if applicable).

CLIENT INFORMATION

☐ M ☐ F

Legal Name *(as it appears on card)* | Birthdate | Age | Weight (if < 110 lbs)

Street Address / Apt. No. | City | State | ZIP | Telephone

Medicare No.\Insurance ID | Group # | Responsible Party or Cardholder Information | Responsible Party Birthdate

Signature of Client/Guardian | Date | Email Address

TO BE COMPLETED BY CLINIC STAFF

Clinic Name | Client Birthdate

I have received a flu shot in the past? ☐ Yes ☐ No

Client has one of the following insurance plans with VACCINE COVERAGE?

☐ Medicare Part B ☐ Medicare HMO Plan
☐ BCBS ☐ BCN
☐ HAP ☐ Health Plus
☐ PHP ☐ Priority Health

<u>Dose 3 Years & Older</u>
0.5 cc Quadrivalent A & B
- ☐ Right Deltoid IM
- ☐ Left Deltoid IM
- ☐ Right Thigh IM
- ☐ Left Thigh IM

<u>Dose 6 - 35 Mths FluZone</u>
0.25 cc Quadrivalent A & B
- ☐ Right Thigh IM
- ☐ Left Thigh IM

<u>High Dose 65 Years & Older</u>
0.5 cc HD Trivalent A & B
- ☐ Right Deltoid IM
- ☐ Left Deltoid IM

Manu/Lot #/Exp | Nurse Signature | Date