Reset Form

2015-16 Visiting Nurse Association Immunization Consent Form

Print

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

☐M ☐F

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

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/RR Medicare

☐ BCBS

☐ Coventry/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 ☐

*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 ☐

*For LAV vaccines only

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 #:***

☐ FluLaval - IM | ☐ **0.25mL** (6-35mnths) **OR** | **LD RD**

☐ Fluzone – IM, ☐ **Pres. Free** | ☐ **0.5mL** | **Other:____**

☐ Fluarix – IM

☐ FluMist – IN

Vaccine Name/Dose and Route: | ***Site:*** | ***Lot #(s):***

☐ Boostrix 0.5mL IM (≥ 10 years) | **LD RD** | BX:

☐ Energix-B 1.0mL IM (≥ 20 years) | **LD RD** | EX:

☐ Havrix 1.0mL IM (≥ 19 years) | **LD RD** | HX:

Nurse Signature: **Date:**

Fee:_________

☐ Cash

☐ Check#______

☐ CC

☐ Bill Employer

☐ BCBS

☐ Coventry/Aetna

☐ Medicare

☐ (Circle one): VNA employee/ board member/ volunteer