2017-18 Visiting Nurse Association Immunization Consent 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: Circle primary insurance:	PART B: Complete insurance information:
Medicare/RR Medicare	Policy Holders Name_____________________________ DOB _______ Male Female
BCBS	Policy ID Number___________________________________ Policy Holder Last 4 of SSN_______
Coventry/Aetna	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 or Neomycin?.. 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

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	□ **0.25mL** (6-35mnths)	**LD RD IN**	
□ Fluzone – IM, □ **Pres. Free**	□ **0.5mL**	**Other:**____	
□ FluLaval - 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:**

- □ Cash
- □ Check#______
- □ CC
- □ Bill Employer
- □ BCBS
- □ Coventry/Aetna
- □ Medicare
- □ (Circle one): VNA Employee/ BM/Volunteer
- □ Voucher