

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:

<input type="checkbox"/> Medicare/RR Medicare <input type="checkbox"/> BCBS <input type="checkbox"/> Coventry/Aetna	Policy Holders Name _____ DOB _____ Male Female Policy ID Number _____ Policy Holder Last 4 of SSN _____ Relationship to insurance holder: Self Child Spouse Partner
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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:

- Fluarix – IM
- Fluzone – IM, Pres. Free
- FluLaval - IM
- FluMist – IN

Dose:

- 0.25mL (6-35mnths)
- 0.5mL

Site:

LD RD IN
Other: _____

Lot #:

Vaccine Name/Dose and Route:

- Boostrix 0.5mL IM (≥ 10 years)
- Energix-B 1.0mL IM (≥ 20 years)
- Havrix 1.0mL IM (≥ 19 years)

Site:

LD RD
LD RD
LD RD

Lot #(s):

BX:

 EX:

 HX:

Nurse Signature: _____

Date: _____

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