

Influenza Vaccination Assessment & Consent Form

Provided by Visiting Nurse Association Home Support Services (VNA)

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS NOTIFY THE NURSE BEFORE IMMUNIZATION:

Y N

- Have you ever had a reaction to a flu shot?
- Are you allergic to eggs or egg products?
- Are you allergic to thimerosal (found in Visine or Murine eye drops)?
- Are you sick with a fever?
- Do you have an active nerve disorder like MS, Parkinson's disease, Lou Gehrig's disease?
- Do you have a history of Guillain-Barre' syndrome (a neurological disorder)?
- Have you received a vaccination for Hepatitis, Tetanus or Pneumonia in the past two weeks?
- Are you currently pregnant?

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 vaccination, please call the Visiting Nurse Association at 248-967-8751.** **If you experience any adverse effects from the Influenza vaccination, please contact your physician and notify the Visiting Nurse Association (also notify your employer if you received your vaccination at work).**

CONSENT AND RELEASE FOR INFLUENZA VACCINE

- I have read the information regarding the influenza vaccination. I have had an opportunity to ask questions, and my questions have been answered to my satisfaction. I understand the benefits and risks of Influenza vaccination as described. I request that the vaccine be given to me. I understand the vaccination is being provided by Visiting Nurse Association Home Support Services (VNA). **I expressly release 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 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 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 VNA/exposed person but not to anyone else unless required/authorized by law.
- I acknowledge that I have received written information on VNA's "Notice of Privacy Practices" prior to the provision of service, and I have had the opportunity to have my questions answered.
- **I have been informed that I am responsible to reimburse the VNA for charges not covered.**
- **I agree to give a copy of this consent form to my employer (if applicable).**

PATIENT INFORMATION (please print)

_____ Male Female / /
 Name (Last, First, Middle) Birth Date Age Weight

_____ _____ _____ _____
 Street Address / Apt. No. City/State Zip Code Telephone Number

_____ _____
 Medicare ID Number Insurance Identification Number & Group Number

_____ _____ _____
 Signature of recipient Date Payment & Volunteer Initial

TO BE COMPLETED BY THE NURSE OR CLERK

Clinic: _____ Date _____ Diagnosis Code: **V04.81**
 Procedure Codes: **90658** Vaccine **G0008** Administration

- Yes No I have received a flu shot in the past.
- Yes No I have kidney disease, have been on dialysis, receive benefits due to the Black Lung Program or disability.
- Yes No **I have Medicare Part A & B and additional insurance.**
- Yes No **I am covered by Medicare Part A & B only.**
- Yes No **I am covered by Medicare Part A only.**
- Yes No I wish to have the Visiting Nurse Association bill Medicare for the cost of my shot.

Dose 3 years and older: **Dose 6 months – 35 months:**
0.5cc Trivalent A & B in right left deltoid, IM **0.25cc** Trivalent A & B in right left thigh, IM

_____ _____
 Manufacturer/Lot No/Exp. Date Signature of Nurse Giving Injection/Date