

H1N1 (TIV) 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 sick with a fever?
 - Have you ever had Guillain-Barre' Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?
 - 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 H1N1 Influenza disease or the H1N1 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 of Southeast Michigan at 248-967-8751. If you experience any adverse effects from the H1N1 Influenza vaccination, please contact your physician and notify the Visiting Nurse Association of Southeast Michigan (also notify your employer if you received your vaccination at work).**

CONSENT AND RELEASE FOR INFLUENZA VACCINE

- I have read the 2009-2010 VIS regarding the H1N1 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 H1N1 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.**

PATIENT INFORMATION (please print)

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

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

Insurance/Medicare ID Number Insurance Group Number & Responsible Party or Cardholder Information

Signature of Recipient/Date Email Address Payment & Volunteer Initial

TO BE COMPLETED BY THE NURSE OR CLERK

Clinic: _____

- Yes No I have received a flu shot in the past.
- Yes No I wish to have the Visiting Nurse Association bill Medicare/my insurance for the administration of my shot.

Dose 3 years and older:
0.5cc Trivalent A & B in right left deltoid, IM

Dose 1 months – 35 months:
0.25cc Trivalent A & B in right left thigh, IM

Lot No/Exp. Date

Signature of Nurse Giving Injection/Date