INFLUENZA VACCINATION
ASSESSMENT & CONSENT FORM

Clinic Name _____

Date _____

☐ Billed ☐ AR ☐ MCIR

Yes No

☐ ☐ Have you received a flu shot in the past?
☐ ☐ If Yes, have you ever had a reaction to a flu shot?
☐ ☐ Are you allergic to eggs, egg products, latex, or thimerosal (found in some eye cosmetics, ear, nose & eye meds)?
☐ ☐ Are you currently sick with a fever greater than 100 degrees Fahrenheit?
☐ ☐ Are you pregnant or a nursing mother?
☐ ☐ Do you have a history of Guillain-Barre' Syndrome or any other neurological disorder?
☐ ☐ Have you ever had a severe allergic reaction? (food, medicine, flu shots, other), i.e. hives, breathing difficulty requiring emergency medical treatment or within 48 hours of a previous vaccine? If yes, specify _____
☐ ☐ Have you had another immunization in the last 14 days? If yes, please list _____
☐ ☐ Are you currently receiving Chemotherapy? Last Treatment? _____ Next Treatment date? _____

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 the vaccination, please call the MC VNA at 800-852-1232. If you experience any adverse effects from the influenza vaccination, please contact your physician and notify MC VNA (also notify your employer if you received your vaccination at work).

CONSENT AND RELEASE FOR INFLUENZA VACCINE

• I have read the Vaccination Information Sheet regarding the influenza vaccine. I have had an opportunity to ask questions, and my questions have been answered to my satisfaction. I understand the benefits and risks of the influenza vaccination as described. I request that the vaccine be given to me. I understand the vaccination is being provided by MC VNA. I expressly release MC VNA from any liability resulting from the influenza vaccine.

• I agree to remain under observation for at least 15 minutes. Should I leave before that period lapses, I expressly release MC 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 an MC VNA employee is exposed to my blood or other body fluids, I agree to have my blood tested for HIV & Hepatitis & the results released to MC VNA/exposed person, but not to anyone else unless required/authorized by law.

• I acknowledge that I have received written information on MC VNA's "Notice of Privacy Practices" prior to the provision of service, and I have had the opportunity to have my questions answered.

• Unless cash\check are indicated below, I wish to have MC VNA bill my insurance for the cost of my shot.

• I acknowledge I am responsible to reimburse MC VNA for charges not covered by insurance or applied to deductible.

CLIENT INFORMATION

_____ ☐ ☐ _____ _____ _____

Legal Name *(as it appears on card)* M F Birthdate (MM\DD\YYYY) Age Weight (if < 110 lbs)

_____ _____ _____ _____ _____

Street Address / Apt. No. City State ZIP Telephone

Client has the following insurance plans with VACCINE COVERAGE?

☐ BCBS *(except TEA prefix or Anthem)* ☐ BCN
☐ HAP *(except CIGNA)* ☐ Medicare Part B ☐ PHP ☐ Priority Health
☐ Cash - Amt: _____ ☐ Check - Number\Amount: _____ ☐ Clinic Paid

_____ _____ _____

Insurance Contract ID *(Enrollee / Subscriber / Member ID)* Responsible Party or Cardholder Name Responsible Party Birthdate

_____ _____ _____

Signature of Client/Guardian Date Email Address

TO BE COMPLETED BY CLINIC STAFF

Afluria Dose *(6 Months & 35 Months)*
0.25 cc Quadrivalent A & B
☐ Single Dose - PF *(CPT 90686)*
☐ Multi-Dose *(CPT 90688)*

Flucelvax *(4 Years & Older)*
0.5 cc Quadrivalent A & B
☐ Single Dose - PF *(CPT 90674)*
☐ Multi-Dose *(CPT 90756)*

Fluad *(65 years & Older)*
0.5 cc HD Trivalent A & B
☐ Single Dose *(CPT 90653)*

☐ Right Deltoid IM
☐ Left Deltoid IM

_____ _____ _____

Lot #/ Exp Date Nurse Signature Date