2016-2017 FLU VACCINE CONSENT

HCMC www.HCMC.org **MVNA** www.MVNA.org

Clinic Number: 39765

PRINT IN INK ONLY- REQUIRED INFORMATION FOR CLIENT RECEIVING VACCINE

(Legal name) Last Name **First Name** **MI**

Date of Birth (MM/DD/YYYY) **Age** **Sex(M/F)** **Daytime Phone Number**

Address

STAFF ONLY
Initial that info was verified: ____________

City **State** **Zip Code**

Employer/Name of Clinic Location

Vaccine Choice	Billing Options		
☐ Quadrivalent Shot ☐ High Dose	**Cash Prices** ☐ Quad Shot - $36 ☐ High Dose - $60	☐ Cash ☐ Check #_________ Total $ Collected _________	☐ Bill Employer

MVNA/HCMC can bill through any insurance. Please note, it is the individual's responsibility to check their coverage with their provider.

(#1) Primary Insurance Name

Primary Insurance ID# **Group #**

If different than individual receiving vaccination:
Policy Holder Last Name **First Name** **Date of Birth (MM/DD/YYYY)**

Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other

(#2) Secondary Insurance Name

Secondary Insurance ID# **Group #**

If different than individual receiving vaccination:
Policy Holder Last Name **First Name** **Date of Birth (MM/DD/YYYY)**

Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other

I release a copy of this consent form to the individual, employer or care provider listed below: ______ (Initial)

Send copy of this consent form to: (If not complete, no record will be sent.)

Name: ____
Address: ____
Address: ____
Phone: ____________________ **Fax (If Applicable):** ____________________

COMPLETION REQUIRED BY PATIENT

Please complete the following six questions	
Attention: If you answer yes to any of the questions, further assessment is needed by the nurse.	
1. Is this the first flu vaccination ever for the person to be vaccinated?	☐Yes ☐No
2. Is the person to be vaccinated presently ill with a fever, sore throat, or cough?	☐Yes ☐No
3. Has the person to be vaccinated ever had Guillain-Barre Syndrome?	☐Yes ☐No
4. Has the person to be vaccinated have an egg allergy, latex allergy or serious medication allergy?	☐Yes ☐No
5. Has the person to be vaccinated ever had a serious reaction after receiving a vaccinations?	☐Yes ☐No
6. Is the person to be vaccinated 65 years of age or older?	☐Yes ☐No

I have received, read, and understand the current Flu or FluMist VIS for the Vaccine provided by Hennepin Health Systems dba MVNA. I have had an opportunity to ask questions and received answers to my satisfaction. I understand the benefits and risks of the vaccination and expressly consent, request and authorize a nurse to administer the vaccine(s) to me. I agree to stay in the general area for fifteen (15) minutes after receiving my vaccination. If I experience any side effects, it is my responsibility to follow up with my physician at my expense. I hereby release Hennepin Health Systems dba MVNA, its officers, employees, agents; and ________________, (company name), its officers, employees, and agents from any and all liability that might arise from vaccination on behalf of me, my heirs and personal representatives. I acknowledge that a copy of Hennepin Health Systems dba MVNA's Notice of Privacy Practices is available to me. I understand that this document provides an explanation of the way in which my health information may be used or disclosed by Hennepin Health Systems dba MVNA and of my rights with respect to my health information. I understand I am financially responsible to Hennepin Health Systems dba MVNA for any balance not covered by my insurance company(ies) indicated above.

Parent/Guardian Signature: 6 months – 17 years: ____

Print Name ____ **Relationship to Patient** ☐ **Mother** ☐ **Father** ☐ **Other**

I am the child's parent, authorized representative, or legal guardian and can provide effective consent for this immunization. If applicable, I authorize my child's school to designate a responsible adult to be present at the immunization and to provide direction or assistance if needed.

Client Signature: 18 and older ____ **Date:** ________________

Print Name ____

NURSE ONLY

Manufacturer	Dose	Age	Site	Lot Number (Sticker)	Expiration Date
Fluzone/Sanofi **Quadrivalent**	☐ 0.25 ml	**6 – 35 months**	Anterolateral Thigh: **L or R** IM Deltoid: **L or R**		
Fluzone/Sanofi **Quadrivalent**	☐ 0.5 ml	3 years & up	IM Deltoid: **L or R**		
FluaLaval/GSK **Quadrivalent**	☐ 0.5 ml	3 years & up	IM Deltoid: **L or R**		
HighDose Fluzone/ Sanofi	☐ 0.5 ml	65 years & up	IM Deltoid: **L or R**		

Vaccine Administrator Signature: ________________________

RN Name (Please Print): ________________________

Date: ____________ Time: ____________ am pm

Vaccine Information Statement (VIS) offered to client: ☐ (RN to check box) VIS Edition: ____/____/2016