Influenza Vaccination Consent Form
2020-2021

DATE:	Clinic number	AGE GROUP _____ 19-64 ______65+

#1 RI resident:	#2 Insured by RI employer	#3 Insured:	#4 Free Care:	# 5 Call Patient
yes ☐ no ☐	yes ☐ no ☐	yes ☐ no ☐	yes ☐	☐

PLEASE PRINT CLEARLY

LAST NAME	FIRST NAME	☐ FEMALE ☐ MALE
ADDRESS (street & number)	**PHONE**	**DATE OF BIRTH** / / Month/Day/Year
CITY	**STATE**	**ZIP**

INSURANCE COMPANY	MEMBER ID	GROUP NUMBER
MEDICARE		XXXXXXXXXXXXXXXXXXXX
BLUE CROSS		XXXXXXXXXXXXXXXXXXXX
TUFTS		XXXXXXXXXXXXXXXXXXXX
UNITED HEALTH		
OTHER (please specify)		

	Please answer the following questions & discuss with the nurse if you answered yes	YES	NO
1	Are you allergic to eggs, egg products, latex or thimerosal?		
2	Have you ever had Guillain-Barre Syndrome a type of paralysis?		
3	Have you received a vaccination within the past 14 days?		
4	Have you ever had a reaction to a flu shot?		
5	Are you pregnant?		
6	Is this your first flu shot?		
7	Are you a Health Care worker?		
8	Are you displaying any COVID symptoms?		
9	Temperature __________		
	PLEASE CONTINUE ON REVERSE SIDE		

High DOSE_______________ **PURCHASED_______________**

CONSENT FOR SERVICES AND VACCINE ADMINISTRATION RECORD

I have read or have had explained to me the information provided about influenza and the influenza vaccine. I have had an opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine and request that the vaccine be given to me or to the person for whom I am authorized to sign. I hereby release Visiting Nurse Home & Hospice from any and all liability associated with the administration and potential side effects as a result of receiving this vaccine.

This record is evidence and/or documentation that you have received the flu vaccine and it will be filed with Visiting Nurse Home & Hospice. They will record what vaccine was given, when the vaccine was given, where the vaccine was given, the name of the company that made the vaccine, the vaccine's lot number, and the name and title of the person who gave the vaccine.

AUTHORIZATION FOR RELEASE OF INFORMATION AND FINANCIAL POLICY

I hereby certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. Visiting Nurse Home & Hospice has provided me with their notice of privacy practices which explains how my protected health information will be used. I authorize the release of all information obtained for payment of services rendered. I request that payment for services to be made to Visiting Nurse Home & Hospice if applicable.

VACCINE INFORMATION STATEMENT

I have received and/or reviewed a copy of the Influenza Vaccine Information Statement dated 8-15-2019.

CLIENT SIGNATURE ____ DATE __________________

FOR CLINIC/OFFICE USE

Dose/Site 0.5 ml given IM
R _____ L _____ Deltoid

Dose/Site 0.7 ml given IM
R _____ L _____ Deltoid

Vaccine Manufacturer: ___________________________________ Vaccine Lot No: ____________________

Signature/Title of Vaccine Administrator: ______________________________ Date: __________________