

PATIENT INFORMATION (PLEASE PRINT)

Last Name: _____ First: _____ Gender: M / F
Address: _____ City: _____ State: _____ Zip Code: _____
Phone: _____ Birthdate: _____ Age: _____ Soc Security: _____
Name of Parent or Guardian: _____ Physician: _____

PATIENT CONSENT

Special Cautions (See Vaccine Information Sheet for details)

- If you have any of the following, obtain vaccination under your doctor's supervision
 - * Have had a serious allergic reaction to eggs or a vaccine component, including Thimerosal
 - * Have had previous severe reaction to flu/pneumonia shots
 - * Have an active neurological disorder (delay until stabilized) or history of Guillain-Barre Syndrome
- If you have an acute infection with fever over 100 F, delay immunization until you are recovered.
- FluMist is limited to healthy persons, aged 2-49. Not approved for pregnant women or 4 and under with asthma/recurrent wheezing**

I have read the information sheet about the influenza/pneumonia vaccine. The information I have provided above is correct and true to my knowledge. I understand the benefits and risks of the vaccination and request that the vaccine be given to me or to the person listed above, for whom I am authorized to make this request. **If insurance denies payment, or my original method of payment is rejected, I agree to be personally responsible for full payment.** I understand all information obtained by the VNA will be used only for treatment, payment, or health operations.

Signature of person to receive vaccine or authorized to sign _____ Date _____

Please initial I authorize:
 _____ Influenza Injection
 _____ Influenza Nasal Mist
 _____ Pneumonia Injection

Flu: \$27 (\$24 cash/check now) FluMist: \$33 (\$30 cash/check now) Pneumonia: \$70 (\$67 cash/check now)

PAYMENT INFORMATION (Please show insurance card to receptionist)

- Qualifies for VACCINE FOR CHILDREN because:**
- Enrolled in Medicaid (Medicaid # _____), No health insurance, American Indian, Alaskan Native
 - Health Insurance does not pay for vaccines (please fill out insurance information below)
- Primary Insurance Carrier:** _____
- Policy Number _____ Group Number _____ Phone # _____
- Subscriber Name:** _____ Patient relationship to subscriber: Self Spouse Child Other
- Patient Pay Full:** Amount \$ _____ cash check # _____ **Patient Pay Partial:** Amount \$ _____ cash check # _____
- Voucher Payment:** Voucher # _____
- Company Pay Full** **Company Pay Partial** Company Name _____

TO BE COMPLETED BY VNA NURSE

- Flu Vaccine IM:** L Deltoid R Deltoid L Lateral Thigh R Lateral Thigh Other _____
- Dose:** 3 yrs & older: 0.5 cc Regular 3 yrs & older: 0.5 cc Pres Free
- 6 mo -35 mos: 0.25 cc Regular 6 mo -35 mos: 0.25 cc Pres Free **Lot Number** _____
- Flu Mist** (live, bilateral intranasal) **Lot Number** _____
- Pneumonia Vaccine IM:** L Deltoid R Deltoid Other _____ **Lot Number** _____
- Second vaccine needed: Yes No *****Nurse Signature** _____
- Vaccine #2** Date _____ Route & Site _____ Nurse _____ Lot# _____