Visiting Nurse Association
1524 Sycamore Street
Iowa City, IA 52240 Phone: 319-337-9686

Date: __________________ **Location:** _____________________________ CHILD

VIS: Flu Shot-(IIV4)-8/7/15 Pneumonia-(PPSV23)-4/24/15 Pneumonia-(PCV13)-11/5/15

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)

1. 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
2. If you have an acute infection with fever over 100 F, delay immunization until you are recovered.

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.

Please initial I authorize:

____ ___________________ _________Influenza Injection

Signature of parent/legal guardian of person to receive vaccine Date _________ Pneumonia Injection

Flu: $36 ($33 cash/check now) **Pneumonia: PPSV23 $120 or PCV13 $185**

PAYMENT INFORMATION (Please show insurance card to receptionist)

❑ **Qualifies for VACCINE FOR CHILDREN because:**

- ❑ Enrolled in Medicaid/ MCO (Medicaid #________________________) Physician______________________________________
  MCO (circle one): United Healthcare – AmeriHealth Caritas – Amerigroup MCO Member ID#________________________________
- ❑ No health insurance
- ❑ Health Insurance does not pay for vaccines (please fill out insurance information below)
- ❑ American Indian, Alaskan Native

❑ **Primary Insurance Carrier:** ______________________Claims Address: _____________________________Phone #:__________

Policy # / Member ID _____________________________________ Group # / Employer___________________________________

Policy Holder:____________________________________ Patient relationship to policy holder: ❑Self ❑Spouse ❑Child ❑Other

❑**Patient Pay Full:** Amount $______ ❑cash ❑check #________ ❑**Voucher Payment:** Voucher #____________________

❑**Company Pay Full** 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**___________________________

❑**Pneumonia Vaccine IM**: ❑L Deltoid ❑R Deltoid ❑Other _______________ **Lot Number**___________________________

Second vaccine needed: ❑Yes ❑ No ***__Nurse Signature__**____

(Over)

<u>Qualifies for Vaccine for Children because:</u>

Enrolled in Medicaid, with Amerigroup, AmeriHealth Caritas or United Healthcare _________
No health insurance _________
American Indian/Alaskan Native_________
Health insurance doesn't pay for vaccines____________

<u>Complete if requesting flu shot</u>**:**

	Yes	**No**	**Don't Know**
1. Is the child to be vaccinated sick today?	☐	☐	☐
2. Does the child have allergies to eggs or to a component of the vaccine?	☐	☐	☐
3. Has the child had a serious reaction to influenza vaccine (or intranasal) in the past?	☐	☐	☐
4. Has the child ever had Guillain-Barre syndrome?	☐	☐	☐

<u>To be completed by nurse:</u>

- Reviewed VFC eligibility
- Reviewed immunization screening questionnaire
- Reviewed use of antipyretics

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Staff signature (see front)