

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.

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 parent/legal guardian of person to receive vaccine Date _____ Please initial I authorize:
 _____ Influenza Injection
 _____ Pneumonia Injection

Flu: \$38 (\$35 cash/check now) Pneumonia: PPSV23 \$132 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 -or- 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: 6 mo & older: 0.5 cc Regular 6 mo & older: 0.5 cc Pres Free
 6 mo -35 mos: 0.25 cc Regular Lot Number _____
- Pneumonia Vaccine IM:** L Deltoid R Deltoid Other _____ Lot Number _____
- Second vaccine needed: Yes No ***Nurse Signature _____

Qualifies for Vaccine for Children because:

Enrolled in Medicaid, with Amerigroup or United Healthcare _____

No health insurance _____

American Indian/Alaskan Native _____

Health insurance doesn't pay for vaccines _____

Complete if requesting flu shot or FluMist:

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

To be completed by nurse:

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

Staff signature (see front)