Visiting Nurse Association **Date:** _____ **Location:** _____ **CHILD**

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

VIS: Flu Shot-(IIV)-8/15/19

Patient Information (Please Print)

Last Name:_____ **First:**_____ **Gender: M / F / Other**

Address: _____ **City:**_____ **State:**_____ **Zip:** _____

Phone: _____ **Birthdate:**_____ **Age:** _____

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.

I authorize: (please initial)

_____ _____ _____ Influenza Regular Injection

Signature of parent or legal guardian of person to receive vaccine Date

Payment Information (Please show insurance card to receptionist/volunteer)

Insurance or MCO Company: _____Phone _____

Claims address _____

Member ID_____ Group # _____

Primary Policy Holder Name _____ Primary Policy Holder Birthdate _____

Patient relationship to policy holder: (circle one) Self Child Other

Qualifies for Iowa Vaccine for Children Program (VFC) because:

Enrolled in Iowa Medicaid _____ Medicaid Id # _____
No health insurance _____
American India/ Alaskan Native _____
Health insurance does not pay for vaccines _____

Patient Pay Full: Cash $_____ Check #_____ Amount $_____

Flu: $38 ($35 cash/check now)

Name: _____ **Date:** _____ **Location**: _____

Complete if requesting flu shot:

	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?	☐	☐	☐

To be completed by nurse:

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

_____
Staff signature

To be completed by VNA Nurse

Flu Vaccine IM: **L** Deltoid **R** Deltoid **L** Lateral Thigh **R** Lateral Thigh **Lot Number**_____

Dose: 0.5 cc Regular 0.5 cc Pres Free

Second Vaccine Needed Yes No

***Nurse Signature** _____