INFLUENZA VACCINATION ASSESSMENT & CONSENT FORM

Michigan Community VNA
HOME HEALTH CARE • HOSPICE • WELLNESS

SCREENING QUESTIONNAIRE	YES	NO
Have you received a flu vaccine in the past?		
If yes, have you ever had a reaction to the flu shot?		
Are you allergic to eggs, egg products, latex or thimerosal (found in some eye cosmetics, ear, nose, & eye meds)?		
Are you currently sick with a fever greater than 100 degress Fahrenheit?		
Are you pregnant or a nursing mother?		
Do you have a history of Guillain-Barre' Syndrome or any other neurological disorder?		
Have you ever had a severe allergic reaction (i.g. hives, breathing difficulty) requiring emergency medical treatment? If yes, specify:		
Have you had another immunization in the last 14 days? If yes, specify:		
Are you currently receiving Chemotherapy?		
If yes, Last Treatment Date? Next Treatment Date?		

If you have any questions about the influenza disease or the influenza vaccination, please ask the nurse for clarification now or call your doctor before requesting the vaccine. If you have any questions or concerns following the vaccination, please call MC VNA at 800-852-1232. If you experience any adverse effects from the influenza vaccination, please contact your physician and notify MC VNA (also notify your employer if you received your vaccination at work).

CONSENT AND RELEASE FOR INFLUENZA VACCINE

- I have read the Vaccination Information Sheet regarding the influenza vaccine. I have had an opportunity to ask questions, and my questions have been answered to my satisfaction. I understand the benefits and risks of the influenza vaccination as described. I request that the vaccine be given to me. I understand the vaccination is being provided by MC VNA. I expressly release MC VNA from any liability resulting from the influenza vaccine.
- I agree to remain under observation for at least 15 min (if requested by the nurse). Should I leave before that period lapses, I expressly release MC VNA from any liability resulting from any adverse reaction to the vaccine which may occur during that period and thereafter. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense. I understand side effects may include, but are not limited to: soreness at the injection site, fever, fatigue, and headache. There is some risk for Guillain-Barre Syndrome. Severe reactions may include anaphylaxis and death.
- In the event an MC VNA employee is exposed to my blood or other body fluids, I agree to have my blood tested for HIV and/or Hepatitis and to have the results released to MC VNA/exposed person, but not to anyone else unless required/authorized by law.
- I acknowledge that I have received written information on MC VNA's "Notice of Privacy Practices" prior to the provision of service, and I have had the opportunity to have my questions answered.
- Unless cash\check are indicated below, I wish to have MC VNA bill my insurance for the cost of my shot.
- I acknowledge I am responsible to reimburse MC VNA for charges not covered by insurance or applied to my deductible.

CLIENT INFORMATION

Legal Name	☐ M ☐ F	Birthdate (MM/DD/YYYY)	Age	Weight (if <110lbs)
		/ /		

Street Address / Apt. No.	City	State	Zip

Phone Number	Email Address

INSURANCE INFORMATION

Member ID	Group ID

☐ Aetna ☐ BCBS ☐ BCN ☐ HAP (except CIGNA) ☐ Humana
☐ Medicare Part B ☐ PHP ☐ Priority Health ☐ United ☐ Not Listed, Specify _____

Responsible Party/Cardholder Name (as it appers on card)	Responsible Party Birthdate
	/ /

Signature of Client/Guardian _____ Date _____

TO BE COMPLETED BY CLINIC STAFF

Flucelvax PF (6 mos & Older)
0.5 cc Quadrivalent A & B
☐ Single dose (CPT 90674)

Fluad (65 years & Older)
0.5 cc HD Quadrivalent A & B
☐ Single dose (CPT 90694)

Right Deltoid IM ☐
Left Deltoid IM ☐

Lot #/ Exp Date	Nurse Signature	Date

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