Seattle Visiting Nurse Association

fight the flu 2014
Don't get the flu. Don't spread the flu.
GET VACCINATED.

2014 INFLUENZA VACCINATION CONSENT FORM

A. PATIENT INFORMATION - Please Print

Last Name (Name as it appears on insurance card, if applicable) **First Name** **MI**

Phone

Cash/Check Amount Paid: $ _____ **Employer to be Billed** (Employer Name) _____

B. COMPLETE ONLY IF WE ARE BILLING YOUR HEALTH INSURANCE PLAN. All information is required. Please have your insurance card available.

Home Address **Apt. or Unit #**

City **State** **Zip Code**

Male **Female** **Date of Birth (MM/DD/YYYY)** **Age** **Health Insurance Plan Name** (Includes Medicare Advantage Plans)

Medicare Part B Coverage ID Number **Member ID#** (This is the ID Number on your Insurance Card)

C. ACKNOWLEDGEMENT and AUTHORIZATION

YES	NO	
☐	☐	Have you ever had a reaction to a flu shot?
☐	☐	Are you allergic to eggs or egg products, chicken proteins, vaccine components, latex products or Thimerosol?
☐	☐	Are you sick with a fever (>100)?
☐	☐	Do you have a history of Guillain-Barre syndrome or an active neurological disorder?
☐	☐	Are you pregnant? If yes please inquire about Thimerosol-Free vaccine.

- I authorize Seattle Visiting Nurse Association (SVNA) records to be released and reviewed by an authorized representative of my third party payer or employer as required for payment. I authorize this information to be released to and reviewed by any federal or state agency only as required by the regulatory or licensing body of that agency.
- I agree to release and hold harmless SVNA and the venue at which the vaccine is being provided, its employees, officers, directors or affiliates from any and all liability that might arise from or is in any way connected with this vaccine.
- I have been offered a copy of the **HIPAA Privacy Notice for SVNA**.
- I have been offered and read a copy of the **Vaccine Information Sheet (VIS)** which explains the risks and benefits. I have had the chance to ask questions before my vaccination.
- I understand that it is recommended that, if this is a first vaccination, I will remain in the area for 15 minutes for assistance should any immediate reaction occur. I understand that if I experience any side effects, it is my responsibility to consult my physician at my expense
- **I understand that I am responsible to reimburse SVNA for charges not covered by my employer, Medicare, or health insurance**.
- By my Signature below I authorize SVNA to give me an influenza vaccination.

Signature:_____ Date: _____

(If under 18 PARENT or GUARDIAN must sign above) Parent/Guardian Print Name Here: _____

TO BE COMPLETED BY NURSE FOR VACCINE ADMINISTERED

INFLUENZA
Dose: 0.5ml IM
VIS Date: 2014
Injection Site:
☐ Right Deltoid ☐ Left Deltoid

ALPHA CODE

VACCINE ADMINISTERED

☐ **TRIVALENT INFLUENZA MDV** ☐ **QUADRIVALENT INFLUENZA MDV**

☐ **TRIVALENT INFLUENZA PFS (Thimerosol Free)** ☐ **QUADRIVALENT INFLUENZA PFS (Thimerosol Free)**

Nurse Signature: _____ Date: _____