Homeland Health Specialists, Inc.
1621 E Hennepin Ave, Ste 230
Minneapolis, MN 55414
877-746-8060

VACCINATION CONSENT for INFLUENZA

Last Name – Please print clearly	First Name	M I	☐ Male ☐ Female	Date of Birth	Age
Street Address	City	State	Zip Code	Home/ Cell Phone Number	

Assignment of Benefits and Responsibility for Payment, Coordination of Care and Operations: I authorize Homeland Health Specialists (HHS) to coordinate my care with other healthcare providers. I understand that immunization information may be shared with the Minnesota Immunization Information Connection (MIIC) as authorized by law. I further authorize HHS to bill my health plan or other payers on my behalf, and to receive direct payment for authorized services. **I agree that it is my responsibility to pay for any health care services not covered by my health plan or company, including but not limited to copayments, deductibles and co insurance**.

Payment Information **Attach a copy of your insurance cards to the consent.**

1st Primary Insurance Carrier	Policy/ID/Member Number	Group/Account Number
2nd Secondary Insurance Carrier	Policy/ID/Member Number	Group/Account Number
☐ Cash Payment $_____	☐ Company Payment Company Name:_____	

Screening for Influenza Vaccine

Please check YES or NO for each question.	**YES**	**NO**
1. Is this your first flu vaccine ever?	☐	☐
2. Are you ill today? (Fever of 100.5 or higher on the day of clinic?)	☐	☐
3. Do you have a serious allergy to eggs, thimerosal or any component of the influenza vaccine?	☐	☐
4. Have you ever had a serious reaction to a previous dose of vaccine?	☐	☐
5. Have you ever had Guillain-Barré Syndrome?	☐	☐
Additional Questions for FLUMIST – AGE 2-49 ONLY - Nurse Verify AGE		
6. Do you have **any** chronic health conditions, including diabetes, asthma, blood disorder, heart disease, lung disease, kidney disease, neurologic disorder, or liver disease?	☐	☐
7. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem; or, in the past 3 months, taken medications that affect the immune system, such as prednisone, other steroids, or drugs to treat rheumatoid arthritis, Crohn's disease, psoriasis, or anticancer drugs; or have radiation treatments?	☐	☐
8. Are you age 2 through 17 years and receiving aspirin therapy or aspirin-containing therapy?	☐	☐
9. Are you a child age 2 through 4 years, and in the last 12 months experienced wheezing or asthma?	☐	☐
10. Are you pregnant or could you become pregnant within the next month?	☐	☐
11. Are you receiving antiviral medications (like Relenza or Tamiflu)?	☐	☐
12. Have you received MMR, varicella, MMRV, shingles or yellow fever vaccinations in the past 4 weeks?	☐	☐
13. Do you have a weakened immune system or do you expect to have close contact with someone whose immune system is severely compromised?	☐	☐

SIGNATURE AND ACKNOWLEDGEMENT

I have read and understand the current Vaccine Information Statement. I have had the opportunity to ask questions and received answers to my satisfaction. I understand the risks and benefits of the vaccination(s) and I expressly consent and authorize a nurse to administer the vaccine(s) to me. I agree to stay in the general area for 15 minutes following my vaccination. I understand that I may revoke or cancel this consent in writing at any time. Revoking consent does not apply to information that has already been disclosed. I also acknowledge that a copy of the NOTICE OF PRIVACY PRACTICES has been made available to me.

_____ _____ Staff Verification

Signature of Patient or Legal Guardian Today's Date

FOR CLINIC USE ONLY – DO NOT WRITE IN THE BOXES BELOW

VACCINE	**VACCINATOR**	**ADMINSTRATION**
Manufacturer: _____ Trade Name:_____ Quadrivalent Dose: _____ Lot #: _____ Expiration Date:_____ Dx code: Z23	**Date of VIS: 08/07/2015** Administered by: Date Administered and VIS provided:	**Intramuscular Injection Site** ☐ Left Deltoid ☐ Right Deltoid ☐ Left Thigh ☐ Right Thigh **FluMist Nasal Spray-Ages 2-49 only** ☐ Intranasal