2015-16 Millard PS - Visiting Nurse Association Immunization Consent Form

Section 1 – PLEASE PRINT LEGIBLY (information for person being immunized).

LEGAL Name (Last, First, MI) | **Date of Birth** | **Age** | **Gender** M F

Address | **City** | **State** | **Zip Code**

Phone | **Email Address**

Section 2 - Please select Yes or No in response to the following questions.

1. Sick or have a fever? ..... Yes No
2. Have an allergy to eggs, latex, aluminum, yeast, thimerosal, Neomycin, Gentamicin*, Arginine*, gelatin*?... Yes No
3. Had a serious reaction to a previous dose of any vaccine?..... Yes No
4. Have any neurological problems, seizures, central nervous system disorders, Guillain-Barre'?..... Yes No
5. Pregnant or planning to be in the next 4 weeks?..... Yes No

*6. Have any chronic health problems, asthma, diabetes, heart or lung disease? ..... Yes No

*7. Have cancer, AIDS, other immune problems, or live with someone who does? ..... Yes No

*8. Take cortisone, prednisone, any other steroids, chemotherapy or get radiation therapy? ..... Yes No

*9. Had any other vaccines in the last 4 weeks? ..... Yes No

*For LAV vaccines only

CONSENT: I acknowledge that the medical information provided above is correct. I have been offered a paper copy or have been able to access an electronic copy of the Notice of Privacy Practices and Vaccine Information Statement, understood the risks/benefits and request that the vaccine be given to me or the person named for whom I am authorized to make this request. I understand that I/the person named, must remain on site for at least 10 minutes to be monitored for the possibility of reaction. I authorize the VNA to use this signature for consent to bill the insurance company/credit card and to authorize payment to the VNA. I understand that I will be responsible for the cost if my insurance does not cover this/these immunization(s). If above client is under 19 years, I attest that I am the child's parent or legal guardian and may provide consent for this/these immunization(s).

Individual OR Parent/ Guardian Signature:

_____ **Date:** _____

Influenza Vaccine/ Route:
□ Fluzone – IM, □ Pres. Free
□ Fluarix - IM
□ FluMist – IN

Dose:
□ 0.25mL (6-35mnths) OR
□ 0.5mL

Site:
LD RD
Other:____

Lot # :

Nurse Signature: Date:

Fee:_____
□ Cash
□ Check#_____
□ CC
□ Bill to Millard PS