KOHLS

2015-2016 FLU VACCINE CONSENT

MVNA

www.MVNA.org

Clinic Number:_____

Clinic Location:_____

Clinic Date:_____

PRINT IN INK ONLY- REQUIRED INFORMATION FOR CLIENT RECEIVING VACCINE

(Legal name)Last Name **First Name** **MI**

Date of Birth (M M D D Y Y Y Y) **AGE** **Sex** **Daytime Phone number**

Address

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

MVNA ONLY
CSR/RN
Initials: _____

Flu Shot			FluMist	No Insurance – KOHL'S Grant	
Accepted Insurance				**Children**	**Adults**
☐Aetna ☐America's PPO ☐Blue Cross B/S ☐HealthPartners ☐Humana ☐Labor Care ☐Medica	☐Medicare ☐MHP ☐MN Health Care (MA) ☐UUAV	☐Preferred One ☐Select Care ☐UCare ☐Unicare ☐United Health Care	☐America's PPO ☐Blue Cross B/S ☐Health Partners ☐Humana ☐Medica ☐Preferred One ☐United Health Care ☐MN Healthcare/MA	☐All children ages: 6 months thru 18 years ☐Flu Shot Quad ☐FluMist	☐Adults ages: 19 and older ☐Flu Shot Quad

Primary Insurance ID# **Group #**

Secondary Insurance ID# **Group #**

Medicare or Medicare Railroad ID#

POLICY HOLDER (IF DIFFERENT THAN CLIENT RECEIVING VACCINATION) ☐**Self** ☐ **Spouse** ☐ **Parent** ☐ **Other**

Last Name **First Name** **MI**

Date of Birth (M M D D Y Y Y Y)

I have received, read, and understand the current Flu or FluMist VIS for the Vaccine provided by MVNA. I have had an opportunity to ask questions and received answers to my satisfaction. I understand the benefits and risks of the vaccination and expressly consent, request and authorize a nurse to administer the vaccine(s) to me. I agree to stay in the general area for fifteen (15) minutes after receiving my vaccination. If I experience any side effects, it is my responsibility to follow up with my physician at my expense. I hereby release MVNA, its officers, employees, agents; and _____, (company name), its officers, employees, and agents from any and all liability that might arise from vaccination on behalf of me, my heirs and personal representatives. I acknowledge that a copy of MVNA's Notice of Privacy Practices is available to me. I understand that this document provides an explanation of the way in which my health information may be used or disclosed by MVNA and of my rights with respect to my health information. I understand I am financially responsible to MVNA for any charges denied by my insurance company (ies) indicated above

Parent/Guardian Signature: 6 months- 17 years: _____

I am the child's parent, authorized representative, or legal guardian and can provide effective consent for this immunization. If applicable, I authorize my child's school to designate a responsible adult to be present at the immunization and to provide direction or assistance if needed.

Client Signature: 18 and older _____

Client Name_____

COMPLETION REQUIRED BY PATIENT

FLU SHOT and FLUMIST

Attention: For Q1-3 a **"Yes"** is a precaution to the vaccine; Q4-5 a **"Yes"** indicates a contradiction and no vaccine will be provided.

ALL	1. Is this the first flu vaccination ever for the person to be vaccinated?	☐Yes ☐No
	2. Does the person to be vaccinated take a prescription blood thinner?	☐Yes ☐No
	3. Is the person to be vaccinated sick today?	☐Yes ☐No
	4. Has the person to be vaccinated ever had Guillain-Barre Syndrome?	☐Yes ☐No
	5. Has the person to be vaccinated had an allergic reaction to a flu shot, eggs, chicken products, Thimerosol (preservatives), gentamicin, gelatin, arginine, or any component of the flu vaccine?	☐Yes ☐No

FLUMIST ONLY (If getting the shot, skip questions below)

Attention: If you answer **"Yes"** to any of the statements **below**, you are **not eligible** to receive FluMist

FLUMIST ONLY	1. Is the person to be vaccinated less than (<) 2 years of age or older than (>) 49 years of age?	☐Yes ☐No
	2. Is the person to be vaccinated currently nursing, pregnant or expect to be pregnant during the flu season (September through March)?	☐Yes ☐No
	3. Does the person to be vaccinated have a history of any of the following; asthma, reactive airway disease or have experienced active wheezing, disease of the lungs, including chronic bronchitis, emphysema or cystic fibrosis, heart disease, high blood pressure, kidney disease, cancer, AIDS/HIV, diabetes, sickle cell disease, thalassemia, blood disease, an organ transplant, impaired immune system, or on immune suppression therapy?	☐Yes ☐No
	4. Is the person to be vaccinated currently taking prescription medicines to prevent or treat influenza in the past 48 hours?	☐Yes ☐No
	5. Is the person to be vaccinated in close contact with a severely immunocompromised individual requiring a protective environment (such as bone marrow transplant recipients)?	☐Yes ☐No
	6. Is the person to be vaccinated under 18 years of age and receiving aspirin or aspirin-containing therapy?	☐Yes ☐No
	7. Is the person to be vaccinated receiving other vaccinations today?	☐Yes ☐No

NURSE ONLY

Manufacturer	Dose	Age	Site	Lot Number (Sticker)	Expiration Date
Fluzone/Sanofi **Quadrivalent**	☐ 0.25 ml	**6 – 35 months**	Anterolateral Thigh: **L or R** IM Deltoid: **L or R**		
Fluzone/Sanofi **Quadrivalent**	☐ 0.5 ml	3 years & up	IM Deltoid: **L or R**		
FluaLaval/GSK **Quadrivalent**	☐ 0.5 ml	3 years & up	IM Deltoid: **L or R**		
FluMist/ MedImmune	☐ 0.2 ml	2 – 49 years	Intranasal		

Vaccine Administrator Signature: _____

RN Name (Please Print): _____

Date: _____ Time: _____ am pm

Vaccine Information Statement (VIS) offered to client: ☐ (RN to check box) VIS Edition: ___/___/2015