Visiting Nurse Association **Date:** _____ **Location:** _____ **ADULT**

1524 Sycamore Street
Iowa City, IA 52240
Phone: 319-337-9686 VIS: Flu Shot-(IIV)-8/6/21

Patient Information (Please Print)

Last Name: _____ **First Name:**_____ **M / F / Other**

Address: _____ **City:** _____**County**_____ **State:** ____ **Zip**_____

Phone: _____ **Birthdate:**_____ **Age:** _____

Patient Consent

Special Cautions (See Vaccine Information Sheet for details)

1. If you have any of the following, obtain vaccination under your doctor's supervision
   * Have had a serious allergic reaction to eggs or a vaccine component, including Thimerosal
   *Have had previous severe reaction to flu/pneumonia shots
   *Have an active neurological disorder (delay until stabilized) or history of Guillain-Barre Syndrome
2. If you have an acute infection with a fever over 100 F, delay immunization until you have recovered from illness.
3. **High Dose Influenza vaccine is for individuals aged 65 years and older to help boost immune response.**

I have read the information sheet about the influenza/pneumonia vaccine. The information I have provided above is correct and true to my knowledge. I understand the benefits and risks of the vaccination and request that the vaccine be given to me or to the person listed above, for whom I am authorized to make this request. **If insurance denies payment, or my original method of payment is rejected, I understand that I will be responsible for the unpaid balance.** I understand all information obtained by the VNA is only for treatment, payment or health operations.

_____ _____
Signature of person to receive vaccine or authorized to sign Date

I authorize:
____ Influenza Regular Injection
____ Influenza High Dose Injection

Payment Information (Please show insurance card to volunteer)

Medicare B: Medicare #_____ (Must have MBI or Social Security #)

Medical Insurance Company: _____Phone _____

Claims address _____

Member ID_____

Primary Policy Holder Name _____

Patient relationship to policy holder: (circle one) Self Spouse Child Other

Patient Pay Full: Cash $_____ Check #_____ Amount $_____

Flu: $42 ($39 cash/check now) High-dose Flu: $86 ($83 cash/check now

Voucher Payment: Voucher #_____ **Company:** _____

Company Pay: _____

Name: _____ Date: _____ Location: _____

Complete if requesting a flu shot:	**Yes**	**No**	**Don't Know**
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to an ingredient of the vaccine?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
4. Has the person to be vaccinated ever had Guillain Barré syndrome?	☐	☐	☐
5. Has the person to be vaccinated ever felt dizzy or faint before, during, or after a shot?	☐	☐	☐
6. Is the person to be vaccinated anxious about getting a shot today?	☐	☐	☐

To be completed by VNA Nurse

Flu Vaccine IM: L Deltoid R Deltoid Other _____ **Lot Number**_____

***Nurse Signature** _____