BORGESS
VNA Home Care

FLU IMMUNIZATION CONSENT (ages 9 and older)

For your convenience, please bring this consent form to the clinic of your choice. For additional consent forms, download and print at **flushot.borgess.com** or call **(269) 382.6735.**

Please Print:

________________________ ________________________ __________

Last Name **First Name** **Middle Initial**

________________________ ________________________ ______ __________

Address **City** **State** **ZIP**

_______-_______-_______ _______ ____________________

Date of Birth **Age** **Phone Number** **Sex (circle): Male Female**

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E-mail Address

ALL MEDICARE PATIENTS – PLEASE COMPLETE THIS SECTION

Patient has Traditional Medicare Part B as the PRIMARY insurance

Medicare Number ______________________________ **(please keep your card out for verification)**

MEDICARE HMO PATIENTS – COMPLETE THIS SECTION IN ADDITION TO SECTION ABOVE

Patient DOES NOT have Medicare Part B as the PRIMARY insurance but has a Medicare Advantage plan (complete below and please use the card that you give to your physician or for hospital visits – your drug plan or your supplemental coverage plan does not pay for the flu immunization):

Medicare HMO ______________________________

Member ID Number ______________________________ **(please keep your card out for verification)**

I understand BVNHC will bill my Medicare Plan, however, I accept full responsibility for any charges not covered by my Medicare Plan.

BVNHC STAFF – Please fill out this section (cardholder must sign below for credit card payments)

Payment: ☐ **Cash** ☐ **Company Voucher**
☐ **Check** ☐ **Bill Company**
☐ **Master Card** ☐ **VISA**

Credit Card Information:

Name on Card______________________ Signature______________________

Address: ______________________ City__________ State________ ZIP______

16 digit credit card number______________________ Exp. Date__________

3 digit code from back of card ______________

Billing/payment information verified by: ______________

continued on back

Please circle the answer on the right side of the page.

1. Are you sick today or running a temperature of 101° F or over? No Yes
2. Are you severely allergic to eggs, egg products, chicken, chicken feathers, or chicken dander? No Yes
3. Do you have a known allergy to contact lens solution or thimerosal (a mercury derivative)? No Yes
4. Do you have a latex allergy? No Yes
5. Have you ever been paralyzed by Guillian Barre Syndrome? No Yes
6. Have you ever had a life-threatening reaction to a flu shot? No Yes
7. Do you have an active neurological disorder which is characterized by unstable or changing neurological symptoms? No Yes
8. Are taking a “blood thinner”/anticoagulant such as Coumadin or Plavix? No Yes
9. Are you or could you be pregnant? No Yes
   If yes, has your physician recommended that you receive a flu shot? No Yes
10. A.) Are you over 65? No Yes B) Do you have asthma? No Yes C.) Do you smoke? No Yes
11. If you are over 60, are you interested in the Zostavax (Shingles) vaccination? No Yes
12. Do you have a latex allergy? No Yes

- **I have read and received a copy of the Inactivated Influenza Vaccine Information Statement prior to my vaccination.**
- **I understand the risks and benefits involved, have had a chance to ask questions which were answered to my satisfaction, and request that the vaccine be given to me.**
- **I agree to stay in the general area for fifteen (15) minutes after receiving my vaccination to ensure that no immediate reactions occur. I understand that if I experience any unusual and severe side effects, it will be my responsibility to follow up with my personal physician at my expense.**
- **The Borgess VNA Privacy Notice is posted at this clinic and a copy was made available to me.**
- **In the event that a health care worker is exposed to my blood or body fluids during the vaccination process, I consent to the testing of my blood for infectious diseases such as Hepatitis, HIV infection or Immunodeficiency Syndrome and I agree to the release of the test results to the exposed individual.**
- **I agree to reimburse BVNAHC if my Medicare Plan rejects payment.**

X____ ______________________________ Date_____________

Signature of person to receive vaccine or person authorized to make this request for patient listed above (if under 18 years of age or physically unable).

Relationship to person receiving vaccine if patient not signing

BVNAHC STAFF USE ONLY

Administered by: ____________________________ Date administered: ___________________________

Nurse Signature/Title

Regular Flu

_ GSK Flulaval (18 yrs & older)

_ Sanofi Fluzone

High Dose Flu

_ Sanofi High Dose Fluzone

Deltoid, 0.5 mL, IM ☐ Left ☐ Right

Lot Code: ☐A ☐B ☐C ☐D ☐E ☐F ☐G ☐H ☐I ☐J ☐K