

Last Name – Please print clearly	First Name	M I	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to disclose	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. If my employer requests proof of flu vaccination, I authorize HHS to share this information with my employer. **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.** If you DO NOT want to HHS to share a proof of vaccination with your employer or program sponsor, initial here: _____

PAYMENT INFORMATION

Attach a copy of your insurance cards to the consent.

1 st Primary Insurance Carrier	Policy/ID/Member Number	Group/Account Number
2 nd Secondary Insurance Carrier	Policy/ID/Member Number	Group/Account Number
<input type="checkbox"/> Patient Payment \$ _____	<input type="checkbox"/> Company Payment	Company Name: _____

SCREENING FOR FLU VACCINE

Please check YES or NO for each question.	YES	NO
1. Is this your first flu vaccine ever?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you ill today? (Fever of 100.5 or higher on the day of clinic?)	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have a serious allergy to eggs, thimerosal or any component of the influenza vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had a serious reaction to a previous dose of vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had Guillain-Barré Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>

STOP* QUESTIONS BELOW FOR FLUMIST ONLY. Must be Age 2-49 to qualify. *STOP

6. Do you have any chronic health conditions, including diabetes, asthma, blood disorder, heart disease, lung disease, kidney disease, neurologic disorder, or liver disease?	<input type="checkbox"/>	<input type="checkbox"/>
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 radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have asplenia, CSF leak, a cochlear implant or are you immunocompromised?	<input type="checkbox"/>	<input type="checkbox"/>
9. Are you age 2 through 17 years and receiving aspirin therapy or aspirin-containing therapy?	<input type="checkbox"/>	<input type="checkbox"/>
10. Are you a child age 2 through 4 years, and in the last 12 months experienced wheezing or asthma?	<input type="checkbox"/>	<input type="checkbox"/>
11. Are you pregnant or could you become pregnant within the next month?	<input type="checkbox"/>	<input type="checkbox"/>
12. Are you receiving antiviral medications (like Relenza or Tamiflu)?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you received MMR, varicella, MMRV, shingles or yellow fever vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you have a weakened immune system or do you expect to have close contact with someone whose immune system is severely compromised?	<input type="checkbox"/>	<input type="checkbox"/>

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 release HHS, all representatives of HHS and the company sponsoring this event for any and all damages, injuries or any adverse reactions which may result from participation into this program. I acknowledge that a copy of the NOTICE OF PRIVACY PRACTICES has been made available to me.

Signature of Patient or Legal Guardian _____	Today’s Date _____	Staff Verification
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FOR CLINIC USE ONLY – DO NOT WRITE IN THE BOXES BELOW

VACCINE	VACCINATOR	ADMINISTRATION
Manufacturer: _____ Trade Name: _____ Dose: _____ Lot #: _____ Expiration Date: _____ Dx code: Z23	Date of VIS: 08/06/21 Administered by: _____ Date Administered and VIS provided: _____	Intramuscular Injection Site <input type="checkbox"/> L Deltoid <input type="checkbox"/> R Deltoid <input type="checkbox"/> L Thigh <input type="checkbox"/> R Thigh FluMist Nasal Spray-Ages 2-49 only <input type="checkbox"/> Intranasal