Visiting Nurse Association
1524 Sycamore Street
Iowa City, IA 52240
Phone: 319-337-9686

Date: _____ **Location:** _____ **CHILD**

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:** _____

Name of Parent or Guardian _____

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 fever over 100 F, delay immunization until you have recovered from illness.

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

Payment Information (Please show insurance card to volunteer)

Medicaid MCO: _____ Medicaid ID_____

Private Medical Insurance: _____ Phone _____

Claims address _____

Member ID_____

Primary Policy Holder Name _____ Patient relationship to policy holder: (pick one)

(●) Self ( ) Child ( ) Other

Qualifies for Iowa Vaccine for Children Program (VFC) because:

Enrolled in Iowa Medicaid ☐
No health insurance ☐
American India/ Alaskan Native ☐
Health insurance does not pay for vaccines ☐

Patient Pay Full: Cash $_____ Check #_____ Amount $_____
Flu: $41 ($38 cash/check now)

Company Pay: _____

Name: _____ **Date:** _____ **Location**: _____

Complete if requesting flu shot:

	Yes	No	Don't Know
1. Is the child to be vaccinated sick today?	○	○	◉
2. Does the child have allergies to eggs or to a component of the vaccine?	○	◉	○
3. Has the child had a serious reaction to influenza vaccine (or intranasal) in the past?	◉	○	○
4. Has the child ever had Guillain-Barre syndrome?	◉	○	○

To be completed by nurse:

- Reviewed VFC eligibility
- Reviewed immunization screening questionnaire
- Reviewed use of antipyretics

_____
Staff signature

To be completed by VNA Nurse

Flu Vaccine IM: **L** Deltoid **R** Deltoid **L** Lateral Thigh **R** Lateral Thigh **Lot Number**_____

Dose: 0.25 cc Regular 0.5 cc Regular 0.5 cc Pres Free

Second Vaccine Needed Yes No

***Nurse Signature** _____