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

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

VIS: Flu Shot-(IIV) - 8/6/21 EUA :Pfizer COVID Bivalent Vaccine

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 and EUA 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/COVID 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 and COVID vaccine and had the opportunity to ask questions. 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 for flu vaccine.** I understand all information obtained by the VNA is only for treatment, payment or health operations.

I authorize:
____ Flu Vaccine
____ COVID Bivalent Booster

_____ _____
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 _____ Relationship to policy holder: 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)

To be completed by VNA Nurse

Flu Vaccine IM: L Deltoid R Deltoid L Lateral Thigh R Lateral Thigh **Lot Number**_____
Dose: 0.5 cc Regular 0.5 cc Pres Free
COVID Vaccine IM: L Deltoid R Deltoid L Lateral Thigh R Lateral Thigh **Lot Number**_____

***Nurse Signature:** Flu _____ Covid_____

Prevaccination Checklist for COVID-19 Vaccination

Name _____

For vaccine recipients (both children and adults):

The following questions will help us determine if there is any reason COVID-19 vaccine cannot be given today. **If you answer "yes" to any question, it does not necessarily mean the vaccine cannot be given.** It just means additional questions may be asked. If a question is not clear, please as the healthcare provider to explain it.

	Yes	No	Don't know
1. How old is the person to be vaccinated? _____			
2. Is the person to be vaccinated sick today?	☐	☐	☐
3. Has the person to be vaccinated ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product was administered? ☐ Pfizer-BioNTech ☐ Janssen *(Johnson & Johnson)* ☐ Another Product ☐ Moderna ☐ Novavax _____			
• How many doses of COVID-19 vaccine were administered? _____			
• Did you bring the vaccination record card or other documentation?	☐	☐	
4. Is the person to be vaccinated have a health condition or undergoing treatment that makes them moderately or severely immunocompromised? *This would include, but not limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], or moderate or severe primary immunodeficiency.*	☐	☐	☐
5. Is the person to be vaccinated received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	☐	☐	☐
6. Has the person to be vaccinated ever had an allergic reaction to: *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of a COVID-19 vaccine	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
7. Has the person to be vaccinated ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

8. Check all that apply to the person to be vaccinated:

- ☐ Have a history of myocarditis or pericarditis
- ☐ Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?
- ☐ History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)
- ☐ Have a history of thrombosis with thrombocytopenia syndrome (TTS)
- ☐ Have a history of Guillain-Barré Syndrome (GBS)
- ☐ Have a history of COVID-19 disease within the past 3 months?

Form reviewed by _____ **Date** _____