

Visiting Nurse Association

1524 Sycamore Street

Iowa City, IA 52240

Phone: 319-337-9686

Date: _____ Location: _____

ADULT

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: _____

Patient Consent

Special Cautions (See Vaccine Information Sheet and EUA for details)

- 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
- If you have an acute infection with fever over 100 F, delay immunization until you have recovered from illness.
- 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 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:

_____ Influenza Regular Injection
 Signature of person to receive vaccine or authorized to sign Date _____ Influenza High Dose Injection
 _____ COVID Bivalent Booster

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: \$41 (\$38 cash/check now) High-dose Flu: \$84 (\$81 cash/check now)

Voucher Payment: Voucher # _____ Company: _____

Company Pay: _____

To be completed by VNA Nurse

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

COVID Vaccine IM Booster: L Deltoid R Deltoid Other _____ 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 ask 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person to be vaccinated ever received a dose of COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> If yes, which vaccine product was administered? <ul style="list-style-type: none"> <input type="checkbox"/> Pfizer-BioNTech <input type="checkbox"/> Janssen (<i>Johnson & Johnson</i>) <input type="checkbox"/> Another Product <input type="checkbox"/> Moderna <input type="checkbox"/> Novavax 			
<ul style="list-style-type: none"> How many doses of COVID-19 vaccine were administered? _____ 			
<ul style="list-style-type: none"> Did you bring the vaccination record card or other documentation? 	<input type="checkbox"/>	<input type="checkbox"/>	
4. Is the person to be vaccinated have a health condition or undergoing treatment that makes them moderately or severely immunocompromised? <i>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.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Is the person to be vaccinated received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the person to be vaccinated ever had an allergic reaction to: <i>(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.)</i>			
<ul style="list-style-type: none"> A component of a COVID-19 vaccine 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> A previous dose of COVID-19 vaccine 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the person to be vaccinated ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? <i>(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.)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Check all that apply to the person to be vaccinated:			
<input type="checkbox"/> Have a history of myocarditis or pericarditis			
<input type="checkbox"/> Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?			
<input type="checkbox"/> History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)			
<input type="checkbox"/> Have a history of thrombosis with thrombocytopenia syndrome (TTS)			
<input type="checkbox"/> Have a history of Guillain-Barré Syndrome (GBS)			
<input type="checkbox"/> Have a history of COVID-19 disease within the past 3 months?			

Form reviewed by _____

Date _____