IIV

Flu shot

Influenza Vaccine 2017-2018

DEPARTMENT OF HEALTH

Contact Information - person being vaccinated

Last Name | First Name | Middle I | Date of Birth

Street Address | City | State | Zip Code | Phone Number

Immunization information may be shared through the Minnesota Immunization Information Connection (MIIC) with other healthcare providers, schools, health departments, and others authorized under law to receive it. If you have any questions, please ask your health care provider. If you decide not to have this information shared with MIIC, please call 1-800-657-3970.

Assignment of Benefits and Responsibilities for Payment: *This allows us to bill your health plan or company and receive payment directly. It also means that you agree to pay for services not covered by your health plan.* I authorize this health provider to bill my health plan or other payers on my behalf, and to receive direct payment of authorized benefits. 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, deductables and co-insurance.

Payment Information

Bring a copy of your insurance card with you!

Primary Insurance Carrier: | Policy/ID/Member Number | Group Number:

Secondary Insurance Carrier: | Policy/ID/Member Number | Group Number:

Policy Holder Name, if different from vaccinee | Name: | Date of Birth:

☐ Cash: | ☐ Company payment: | Company Name:

Agreement

I have read or had explained to me the Vaccine Information Statement "Influenza Vaccine: What You Need to Know." I have had the chance to ask questions which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the influenza vaccination be given to me or to the person named above for whom I am authorized to make this request. I also acknowledge that a copy of the NOTICE OF PRIVACY PRACTICES has been made available to me.

Signature of Patient or Legal Guardian: _____ Date: _____ Verification: _____

Health History

No	Yes	
☐	☐	1. Are you sick today? (Fever of 100.5 or higher on the day of the clinic)
☐	☐	2. Have you ever had Guillain-Barré Syndrome within 6 weeks of an influenza vaccination?
☐	☐	3. Do you have a life-threatening allergy to eggs?
☐	☐	4. Do you have a life-threatening allergy to a component of the vaccine? May include antibiotics, gelatin or latex.
☐	☐	5. Have you ever had a reaction to a dose of flu vaccine that needed immediate medical attention?

For Clinic Use Only - Do Not Write In This Box

Vaccine

☐ GSK ☐ Sanofi ☐ RIV ☐ Sequris

◯ Intradermal ◯ High Dose ◯ Adjuvanted

Dose: ☐ .1 ml ☐ .25 ml ☐ .5 ml

Lot #: | Exp. Date:

Vaccinator

☐ VIS 8/7/15 provided

Administered by:

Date:

Clinic site:

Administration

☐ Left Deltoid ☐ Right Deltoid

☐ Left Thigh ☐ Right Thigh