New Milford Visiting Nurse and Hospice
Influenza Immunization Consent

Patient Name (as it appears on insurance card)	**Gender** ☐ **Male** ☐ **Female**	**Date of Birth**
Address (Street number and street name – no Post Office Box)	**City, State**	**Zip**
Home or Cell Phone	**Work Phone**	

PRIMARY INSURANCE INFORMATION: Please check your insurance; fill in your insurance ID# and Policy's Holder's name

☐ Aetna
☐ Aetna Medicare Advantage
☐ Anthem/Blue Cross
☐ Blue Cross (other than Anthem)
☐ ConnectiCare
☐ ConnectiCare Medicare VIP
☐ Medicare Part B
☐ Healthy CT

Insurance ID #_____

What is the name of the person who is the Policy Holder?

_____

What is the Policy Holder's date of birth? ___/___/____

Direct Payment

☐ No insurance coverage

Paid by: ☐ Cash ☐ Check Amount Paid $_____

PLEASE ANSWER THE FOLLOWING QUESTIONS

1. Are you allergic to eggs or to the preservative thimerosal? ☐ Yes ☐ No
2. Have you ever had a reaction to any vaccine? ☐ Yes ☐ No
3. Have you ever been diagnosed with Guillain-Barre Syndrome? ☐ Yes ☐ No
4. Are you sick with a fever today? ☐ Yes ☐ No
5. If you are under age 50, are you interested in receiving FLUMIST? ☐ Yes ☐ No

If you answered YES to question #5, please answer the following questions, otherwise skip.

a. Do you or anyone living with you have a severely compromised immune system? ☐ Yes ☐ No
b. Are you in close contact at work or otherwise with someone who has had a transplant or has a compromised immune system? ☐ Yes ☐ No
c. Do you have chronic health issues such as: asthma, diabetes, heart, lung, kidney, or liver disease? ☐ Yes ☐ No
d. Are you pregnant or is there a chance you might become pregnant? ☐ Yes ☐ No
e. Do you suffer from a muscle or nerve disorder such as seizure disorders or cerebral palsy? ☐ Yes ☐ No
f. Have you been immunized with a live vaccine (MMR, varicella) within the past 4 weeks? ☐ Yes ☐ No

I have read the Influence Vaccine Information Statement dated 08/07/15. I have had a chance to ask questions and I understand the benefits and risks of the vaccine. I request that the vaccination be given to me (or to the person for whom I am authorized to make this request.) I authorize the release of any medical or other information necessary to process the insurance claim or for the other public health purpose. I have read the Notice of Privacy Practices.

I agree to pay all unpaid charges billed to me by New Milford Visiting Nurse and Hospice. I understand I will receive a bill from NMVNA for any portion of this claim my insurance company does not pay and I agree to pay the bill in full within 30 days of receipt.

Signature:_____ Print Name: _____

STAFF USE ONLY

Place vaccine label here or complete: Vaccine Brand: _____ Lot # _____ Exp. Date: _____

☐Standard ☐Flu Mist ☐T-Free

Site: ☐ **L Arm** ☐ **R Arm** ☐ **Intranasal** **Administered by:**_____ **Date**____/____/**2015**