New Milford Visiting Nurse and Hospice
Pediatric 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
☐ Anthem/Blue Cross
☐ Blue Cross (other than Anthem)
☐ ConnectiCare
☐ Medicaid (Husky B/SCHIP)
☐ Other_____
☐ 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

☐ Other insurance not listed

☐ Medicaid or no coverage (6 months to 59 months)

Paid by: ☐ Cash ☐ Check Amount Paid $_____

PLEASE ANSWER THE FOLLOWING QUESTIONS

Is your child sick with a fever today?	☐ Yes	☐ No
Does your child have an allergy to eggs or thimerosal?	☐ Yes	☐ No
Has your child ever had a reaction to any vaccine?	☐ Yes	☐ No
Has your child ever been diagnosed with Guillain-Barre Syndrome?	☐ Yes	☐ No

IF YOUR CHILD IS 6 MONTHS THROUGH 8 YEARS OF AGE PLEASE ANSWER THE FOLLOWING:

Has your child ever received a flu vaccine?	☐ Yes	☐ No

FLUMIST: PLEASE ANSWER ONLY IF THIS CHILD IS GOING TO RECEIVE THE FLUMIST

Is this child younger than 2 years old?	☐ Yes	☐ No
Is this child receiving aspirin therapy or aspirin-containing therapy?	☐ Yes	☐ No
Is this child pregnant or is there a chance she is pregnant?	☐ Yes	☐ No
Does anyone living with this child have a severely compromised immune system or has had a transplant?	☐ Yes	☐ No
Has this child received MMR or varicella vaccine in the past 4 weeks?	☐ Yes	☐ No
In the last 12 months, has a healthcare provider told you that this child had wheezing or asthma?	☐ Yes	☐ No
Does this child have a weakened immune system?	☐ Yes	☐ No
Does this child have long-term health problems such as asthma, diabetes, heart, lung, kidney, or liver disease?	☐ Yes	☐ No
Does this child suffer from a muscle or nerve disorder such as seizure disorders or cerebral palsy?	☐ 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 ☐FluMist ☐T-Free Site: ☐ L Arm ☐ R Arm ☐ L Leg ☐ R Leg ☐ Intranasal

Administered by:_____ Date____/____/2015