Homeland Health Specialists, Inc.
1621 E Hennepin Ave, Ste 230
Minneapolis, MN 55414
877-746-8060

HOMELAND HEALTH SPECIALISTS

VACCINATION CONSENT for INFLUENZA

Last Name – Please print clearly	First Name	M I	☐ Male ☐ Female ☐ Prefer not to disclose	Date of Birth	Age
Street Address	City	State	Zip Code	Home/Cell Phone Number	

Assignment of Benefits and Responsibility for Payment, Coordination of Care and Operations: I authorize Homeland Health Specialists (HHS) to coordinate my care with other healthcare providers. I understand that immunization information may be shared with the Minnesota Immunization Information Connection (MIIC) as authorized by law. I further authorize HHS to bill my health plan or other payers on my behalf, and to receive direct payment for authorized services. If my employer requests proof of flu vaccination, I authorize HHS to share this information with my employer. **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, deductibles and co-insurance**. If you DO NOT want to HHS to share a proof of vaccination with your employer or program sponsor, initial here: _____ Initial

Payment Information **Attach a copy of your insurance cards to the consent.**

1st Primary Insurance Carrier	Policy/ID/Member Number	Group/Account Number
2nd Secondary Insurance Carrier	Policy/ID/Member Number	Group/Account Number

Screening for Influenza Vaccine

Please check YES or NO for each question.	**YES**	**NO**
1. Is this your first flu vaccine ever?	○	○
2. Are you ill today? (Fever of 100.5 or higher on the day of clinic?)	○	○
3. Do you have a serious allergy to eggs, thimerosal or any component of the influenza vaccine?	○	○
4. Have you ever had a serious reaction to a previous dose of vaccine?	○	○
5. Have you ever had Guillain-Barré Syndrome?	○	○
Additional Questions for FLUMIST – AGE 2-49 ONLY - Answer 6-13 for FluMist ONLY	STOP	HERE
6. Do you have **any** chronic health conditions, including diabetes, asthma, blood disorder, heart disease, lung disease, kidney disease, neurologic disorder, or liver disease?	○	○
7. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem; or, in the past 3 months, taken medications that affect the immune system, such as prednisone, other steroids, or drugs to treat rheumatoid arthritis, Crohn's disease, psoriasis, or anticancer drugs; or have radiation treatments?	○	○
8. Do you have asplenia, CSF leak, a cochlear implant or are you immunocompromised?	○	○
9. Are you age 2 through 17 years and receiving aspirin therapy or aspirin-containing therapy?	○	○
10. Are you a child age 2 through 4 years, and in the last 12 months experienced wheezing or asthma?	○	○
11. Are you pregnant or could you become pregnant within the next month?	○	○
12. Are you receiving antiviral medications (like Relenza or Tamiflu)?	○	○
13. Have you received MMR, varicella, MMRV, shingles or yellow fever vaccinations in the past 4 weeks?	○	○
14. Do you have a weakened immune system or do you expect to have close contact with someone whose immune system is severely compromised?	○	○

SIGNATURE AND ACKNOWLEDGEMENT

I have read and understand the current Vaccine Information Statement. I have had the opportunity to ask questions and received answers to my satisfaction. I understand the risks and benefits of the vaccination(s) and I expressly consent and authorize a nurse to administer the vaccine(s) to me. I agree to stay in the general area for 15 minutes following my vaccination. I release HHS, all representatives of HHS and the company sponsoring this event for any and all damages, injuries or any adverse reactions which may result from participation into this program. I acknowledge that a copy of the NOTICE OF PRIVACY PRACTICES has been made available to me.

_____ Signature of Patient or Legal Guardian

_____ Today's Date

Staff Verification

FOR CLINIC USE ONLY – DO NOT WRITE IN THE BOXES BELOW

VACCINE
Manufacturer: _____
Trade Name: _____
Quadrivalent
Dose: _____
Lot #: _____
Expiration Date: _____
Dx code: Z23

VACCINATOR
Date of VIS: 08/15/2019
Administered by:
Date Administered and VIS provided:

ADMINSTRATION
Intramuscular Injection Site
☐ Left Deltoid ☐ Right Deltoid
☐ Left Thigh ☐ Right Thigh

FluMist Nasal Spray-Ages 2-49 only
☐ Intranasal