

**DVNA Flu Prevention Services – 2011 Adult Influenza Immunization Consent**

For staff only

Name: \_\_\_\_\_  Male  Female Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_

Address: \_\_\_\_\_  
No PO box please City State Zip

Home or Cell: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Clinic Location: \_\_\_\_\_

**INSURANCE INFORMATION: Please mark your insurance, fill in your insurance ID# and policy holder's name.**

Anthem/Blue Cross  Aetna  Oxford  Cigna  ConnectiCare  
 Medicare Part B Do you have a Medicare Advantage Plan?  Yes  No

Insurance ID # \_\_\_\_\_ Name of Policy Holder: \_\_\_\_\_

*Form of Payment* IF YOU DO NOT HAVE ANY OF THESE INSURANCE COMPANIES PLEASE MARK YOUR FORM OF PAYMENT BELOW. DO NOT MARK A PAYMENT IF YOU FILLED IN AN INSURANCE ID THAT WE ACCEPT.  
 Cash  Check # \_\_\_\_\_  Master Card  VISA

***I agree that if my insurance company does not pay for the vaccine or if a co-payment or deductible applies, I will receive a bill from DVNA and that I am responsible for payment.***

**Please answer the following:**

Are you allergic to eggs or to the preservative thimerosal?  Yes  No  
 Have you ever had a reaction to any vaccine?  Yes  No  
 Have you ever been diagnosed with Guillain-Barré Syndrome?  Yes  No  
 Are you sick with a fever today?  Yes  No  
 If you are age 65 or older, are you interested in the Sanofi High Dose flu vaccine?  Yes  No

**Please answer the following ONLY IF you are younger than 50 and interested in the Flu Mist vaccine.**

Are you 50 years of age or older?  Yes  No  
 Do you or anyone living with you have a severely compromised immune system?  Yes  No  
 Do you have chronic health problems?  Yes  No  
 Are you pregnant?  Yes  No  
 Have you had one or more episodes of asthma within the past year?  Yes  No  
 Have you been immunized with a live vaccine (MMR, varicella) within the past 4 weeks?  Yes  No

I have read the Influenza Vaccine Information Statement dated 7/26/2011. 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 other public health purpose. I have read the Notice of Privacy Practices.

Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_

(Staff Use Only)  
 Sanofi/Fluzone (Std. Vial)  Sanofi/Fluzone (T-Free)  Sanofi/Fluzone (High Dose)  GSK/Fluarix (T-Free)  GSK/Flulaval (Std. Vial) **Dose: 0.5ml**  
 Flu Mist (Nasal Spray)  
 Lot #: \_\_\_\_\_ Exp: \_\_\_\_\_  
 Site:  L arm  R arm  Intranasal  
 Given by: \_\_\_\_\_ Date: \_\_\_\_\_