

For staff only

DVNA Flu Prevention Services

Danbury Visiting Nurses Association, Inc. - 2008 Influenza Immunization Consent Form

Patient Information - Please print legibly

Name: _____	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of Birth: _____	Age: _____
Address: _____		City	State	Zip
Home Phone: _____	Work Phone: _____			

Select one Method of Payment:

<input type="checkbox"/> Anthem Blue Cross	ID# _____	(include letters)	Name of Policy Holder: _____
<input type="checkbox"/> Oxford	ID# _____		Name of Policy Holder: _____
<input type="checkbox"/> Health Net	ID# _____	HN	Name of Policy Holder: _____
<input type="checkbox"/> ConnectiCare	ID# _____		Name of Policy Holder: _____
<input type="checkbox"/> Aetna	ID# _____		Name of Policy Holder: _____
<input type="checkbox"/> Medicare Part B	ID# _____	(include letters)	
<input type="checkbox"/> Cash / Charge			
<input type="checkbox"/> Check			
<input type="checkbox"/> Billed to company			

Please answer the following:

Are you allergic to eggs or to the preservative thimerosal?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had a reaction to any vaccine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been diagnosed with Guillain-Barré Syndrome?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you sick with a fever today?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

I have received the influenza Vaccine Information Statement. 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 have received a copy of Notice of Privacy Practices. I authorize the release of any medical or other information necessary to process the insurance claim or for other public health purpose.

***I agree that if my insurance company does not pay for the vaccine or if a co-pay or deductible applies, I will be responsible for payment.

Signature: _____

(Staff Use Only)	Influenza			
<input type="checkbox"/> Sanofi/Fluzone	<input type="checkbox"/> GSK/Fluarix	<input type="checkbox"/> GSK/Flulaval	<input type="checkbox"/> Novartis/Fluvirin	
Lot # _____	Exp: 6/09			
Dose: 0.5ml				
Site: <input type="checkbox"/> L arm <input type="checkbox"/> R arm				
Given by: _____		Date: _____		Location: _____