SPECTRUM HEALTH

Visiting Nurse Association 1401 Cedar St. NE Grand Rapids, MI 49503 (616) 486-3900

INFLUENZA VACCINE CONSENT FORM

PLEASE COMPLETE ALL INFORMATION BELOW TO RECEIVE YOUR VACCINATION

Legal Last Name | **Legal First Name** | **MI**

Previous/Alternate Last Name | **Date of Birth (month/ day/ year) *required** | **Age**

Address Number | **Apt #** | **Street Name**

City | **State** | **Zip Code**

Area Code | **Phone number** | **Weight (if < 100 Lbs.)** | **Gender (check box)** ☐ M ☐ F

Race/Ethnicity

☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Native American ☐ Unknown/Other:

HEALTH QUESTIONS	YES	NO
• Have you had a flu shot before?	☐	☐
• Are you allergic to any vaccine component (such as Thimerosal, Influenza)?	☐	☐
• Do you have an active illness (infection/fever) that prevents you from participating in any daily activities?	☐	☐
• Have you ever had an allergic reaction to eggs, egg products, or chicken protein?	☐	☐
• Do you have a past history of Guillian-Barre Syndrome (a nervous system disorder)?	☐	☐

By signing this form I verify that I have received and read the VIS about immunizations that I am receiving. I have had a chance to ask questions which were answered to my satisfaction. I acknowledge that I am notified pursuant to Michigan law, that I may be tested for the presence of HIV, HIV antibody, Hepatitis B and Hepatitis C without my consent if any health professional or health facility employee sustains a needle stick, mucous membrane or open wound exposure to my blood or other body fluids. This test is permitted by Michigan law. I acknowledge that I have received the Spectrum Health HIPAA Notice of Privacy Practices. I believe I understand the benefits and risks of the vaccine(s) that I am receiving and request that the vaccine(s) be given to me or to the person named above for whom I am authorized to make the request. I authorize Spectrum Health Visiting Nurse Association to bill my insurance for services rendered. **I understand that if my insurance denies payment, or only authorizes partial payment in accordance to my POLICY, I will be responsible to pay SH/VNA the charges in full.**

SIGNATURE: Patient/Authorized Representative & Relationship | **Date**

If Age <19 - Parent/Guarantor Name | **Date of Birth** | **Gender** | **Relationship to Patient**

VNA USE ONLY BELOW THIS LINE

☐ **INSURANCE**

My PRIMARY Insurance is: _____

Does the card say Medicare? YES___ NO___

Primary Card Holder's name if different: _____

Primary Card Holder's DOB _____ **Gender ___M ___F**

Insurance ID Number: _____

OR

☐ **PRIVATE PAY**

☐ Cash

☐ Check # _____

☐ Employer Pays

Amount Paid $_____

DOSE: ☒ **0.5ml** **VIS:** ☐ YES ☐ NO

LOT CODE: A B C D E F G H I J K L

SITE: ☐ **Right Deltoid** ☐ **Left Deltoid**

Other_____

NURSE SIGNATURE/TITLE | **DATE**

Flu : **NPI 1659356061 TAX ID #38-1359195**
BCBS NPI 1134567662
Physician: Iris Fay Boettcher, MD

Clinic ID# MONT2801 **Clerk's Initials** _____