

	2017-2018 FLU VACCINE Registration Form HCMC MVNA www.HCMC.org www.MVNA.org	Clinic Number: _____ Employer/Name of Clinic Location: _____
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PRINT IN INK ONLY- REQUIRED INFORMATION FOR CLIENT RECEIVING VACCINE

(Legal name) Last Name	First Name	Middle Name											
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 35%; height: 25px;"></td> <td style="width: 30%; height: 25px;"></td> <td style="width: 35%; height: 25px;"></td> </tr> </table>													
Date of Birth (MM/DD/YYYY)	Age	Sex(M/F)	Phone Number	<input type="checkbox"/> Home or	<input type="checkbox"/> Cell	SSN – last 4 digits							
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; height: 25px;"></td> <td style="width: 15%; height: 25px;"></td> <td style="width: 15%; height: 25px;"></td> <td style="width: 15%; height: 25px;"></td> <td style="width: 15%; height: 25px;"></td> <td style="width: 15%; height: 25px;"></td> <td style="width: 20%; height: 25px;"></td> </tr> </table>													
Address													
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City			State		Zip Code								
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 75%; height: 25px;"></td> <td style="width: 12.5%; height: 25px;"></td> <td style="width: 12.5%; height: 25px;"></td> <td style="width: 12.5%; height: 25px;"></td> </tr> </table>							<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; height: 25px;"></td> <td style="width: 50%; height: 25px;"></td> </tr> </table>						

Vaccine Choice	Billing Options			
<input type="checkbox"/> Quadrivalent Shot <input type="checkbox"/> High Dose- 65 years and older only	Cash Prices <input type="checkbox"/> Quad Shot - \$38 <input type="checkbox"/> High Dose - \$65	<input type="checkbox"/> Cash <input type="checkbox"/> Check # _____ Total \$ Collected _____	<input type="checkbox"/> Bill Employer	<input type="checkbox"/> MnVFC – Must be 18 or younger AND one of the following: (Select category) <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Uninsured <input type="checkbox"/> MA, MHCP, or MNCare

MVNA/HCMC can bill through any insurance. Please note, it is the individual's responsibility to check their coverage with their provider.

(#1) Primary Insurance Name <table style="width: 100%; border-collapse: collapse;"> <tr><td style="height: 25px;"></td></tr> </table> Primary Insurance ID# <table style="width: 100%; border-collapse: collapse;"> <tr><td style="height: 25px;"></td></tr> </table> Group # <table style="width: 100%; border-collapse: collapse;"> <tr><td style="height: 25px;"></td></tr> </table>				(#2) Secondary Insurance Name <table style="width: 100%; border-collapse: collapse;"> <tr><td style="height: 25px;"></td></tr> </table> Secondary Insurance ID# <table style="width: 100%; border-collapse: collapse;"> <tr><td style="height: 25px;"></td></tr> </table> Group # <table style="width: 100%; border-collapse: collapse;"> <tr><td style="height: 25px;"></td></tr> </table>			

Policy Holder: Self (skip section below) Spouse Parent Other

Check if applicable:
 Same Address as Patient
 Same Phone as Patient

Policy Holder Demographics – Complete if different than individual receiving vaccination:

Policy Holder Last Name	First Name						
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Daytime Phone Number	Date of Birth (MM/DD/YYYY)						
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Address							
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City	State Zip Code						
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ONLY complete this box if patient is under 18 years of age:

Who is responsible for the bill?
 Same as Policy Holder
 Other: (If other, must complete information below)

Full Name: _____

Address: _____

Phone: _____

Relationship to patient: _____

COMPLETION REQUIRED BY PATIENT

Please complete the following six questions

Attention: If you answer yes to any of the questions, further assessment is needed by the nurse.

1. Is this the first flu vaccination ever for the person to be vaccinated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is the person to be vaccinated presently ill with a fever, sore throat, or cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has the person to be vaccinated ever had Guillain-Barre Syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has the person to be vaccinated have an egg allergy, latex allergy or serious medication allergy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has the person to be vaccinated ever had a serious reaction after receiving a vaccinations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Is the person to be vaccinated 65 years of age or older?	<input type="checkbox"/> Yes <input type="checkbox"/> No

I have received, read, and understand the current Flu or FluMist VIS for the Vaccine provided by Hennepin Health Systems dba MVNA. I have had an opportunity to ask questions and received answers to my satisfaction. I understand the benefits and risks of the vaccination and expressly consent, request and authorize a nurse to administer the vaccine(s) to me. I agree to stay in the general area for fifteen (15) minutes after receiving my vaccination. If I experience any side effects, it is my responsibility to follow up with my physician at my expense. I hereby release Hennepin Health Systems dba MVNA, its officers, employees, agents; and _____, (company name), its officers, employees, and agents from any and all liability that might arise from vaccination on behalf of me, my heirs and personal representatives. I acknowledge that a copy of Hennepin Health Systems dba MVNA's Notice of Privacy Practices is available to me. I understand that this document provides an explanation of the way in which my health information may be used or disclosed by Hennepin Health Systems dba MVNA and of my rights with respect to my health information. **I understand I am financially responsible to Hennepin Health Systems dba MVNA for any balance not covered by my insurance company(ies) indicated above.**

Parent/Guardian Signature: 6 months – 17 years: _____

Print Name _____ **Relationship to Patient** Mother Father Other

I am the child's parent, authorized representative, or legal guardian and can provide effective consent for this immunization. If applicable, I authorize my child's school to designate a responsible adult to be present at the immunization and to provide direction or assistance if needed.

Client Signature: 18 and older _____ **Date:** _____

Print Name _____

NURSE ONLY

Manufacturer	Dose	Age	Site	Lot Number (Sticker)	Expiration Date
Fluzone/Sanofi Quadrivalent	<input type="checkbox"/> 0.25 ml	6 – 35 months	Anterolateral Thigh: L or R		
			IM Deltoid: L or R		
Fluzone/Sanofi Quadrivalent	<input type="checkbox"/> 0.5 ml	3 years & up	IM Deltoid: L or R		
FluaLaval/GSK Quadrivalent	<input type="checkbox"/> 0.5 ml	3 years & up	IM Deltoid: L or R		
HighDose Fluzone/ Sanofi	<input type="checkbox"/> 0.5 ml	65 years & up	IM Deltoid: L or R		

Vaccine Administrator Signature: _____

RN Name (Please Print): _____ Date: ____/____/2017

Vaccine Information Statement (VIS) offered to client: (RN to check box) VIS Edition: ____/____/____