Hennepin Healthcare

2020-2021 Flu Vaccine Registration Form

BILL INSURANCE/BILL INDIVIDUAL

Clinic # 48358 October 26, 2020 **Employer/name of clinic** Providence Academy

PRINT IN INK ONLY. REQUIRED INFO FOR CLIENT RECEIVING VACCINE.

Last name

First name

Middle name **SSN – last 4 digits**

Sex (M/F) **Date of birth (MM/DD/YYYY)** **Age**

Address

City

State **Zip**

Phone ☐ **Home or** ☐ **Cell**

COMPLETE THIS BOX IF THE PATIENT IS UNDER 18 YEARS OF AGE

Please provide parent/guarantor info below.

☐ Same as the Policy Holder
(must fully complete Policy Holder box)

☐ Other: (If other, must complete information below)

Full name _____

Address _____

_____

Date of birth _____

Phone _____

Relationship to patient _____

MVNA20190501

PAYMENT OPTIONS

☐ **Bill insurance**
*Accurate and complete information below is required for successful billing

☐ **MnVFC**
18 and under – must meet one of these criteria:
☐Uninsured
☐MHCP (MA/MnCare)
☐American Indian or Alaskan Native

☐ **Grant covered**
*Adults may qualify at pre-arranged clinics

☐ **Pay cash or check**
Cash prices:
Standard: $39
High Dose: $70
FluMist: $44
Check #____

Hennepin Healthcare dba MVNA can bill through any insurance. It is the individual's responsibility to check their coverage.

(#1) Primary insurance company name

Insurance ID#

Group #

(#2) Secondary insurance company name

Insurance ID#

Group #

POLICY HOLDER/SUBSCRIBER

☐ **Self (skip section below)** ☐ **Spouse** ☐ **Parent** ☐ **Other**

Policy holder last name

First name

Sex (M/F) **Date of birth (MM/DD/YYYY)**

Daytime phone number ☐ **Same phone as patient**

Policy holder address ☐ **Same address as patient**

City **State** **Zip**

PLEASE COMPLETE THE FOLLOWING QUESTIONS, CHECK "YES" OR "NO." **Attention:** If you answer "yes" to any of the questions, further assessment will be needed by the nurse.	**Y**	**N**
1. Does the person to be vaccinated have any allergies to medications, eggs, or a vaccine component?		
2. Has the person to be vaccinated ever had a serious reaction after receiving a vaccine?		
3. Has the person to be vaccinated had Guillan-Barre Syndrome within 6 weeks of a flu vaccination?		
4. Has the person to be vaccinated already received the flu vaccine for this flu season?		
5. Is the person to be vaccinated presently ill with a fever, sore throat, or cough?		
6. Is the person to be vaccinated 65 years or older?		
Only answer questions 7 – 16 if you are interested in receiving the FluMist nasal spray.		
7. Is the person to be vaccinated younger than 2 years or 50 years or older?		
8. Does the person to be vaccinated have any of the following: HIV, cancer, organ or bone marrow transplant, rheumatoid arthritis, Crohn's disease, multiple sclerosis, Lupus, psoriasis, or reduced immune activity?		
9. Does the person to be vaccinated take any medication that affects the immune system such as prednisone, azathioprine (Imuran), cyclosporine, methotrexate, rituximab, Orencia, or Remicade?		
10. Is the person to be vaccinated in close contact with anyone whose immune system is severely compromised?		
11. Has the person to be vaccinated received any vaccinations in the past 4 weeks?		
12. Has the person to be vaccinated received influenza antiviral medications in the past 48 hours?		
13. Is the person to be vaccinated pregnant or you could become pregnant in the next month?		
14. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorder?		
15. Is the child between 2 and 4 years of age, and has been told they have wheezing or asthma?		
16. If under 18 years, does the person to be vaccinated receive aspirin therapy or aspirin-containing therapy?		

I had an opportunity to review the CDC VIS for influenza vaccine today and ask questions and received answers to my satisfaction. I understand the benefits and risks of the vaccination and expressly authorize a nurse to administer the vaccine to me. I hereby release Hennepin Health Systems (HHS) dba MVNA, its officers, employees, agents; and Providence Academy, (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 HHS dba MVNA's Notice of Privacy Practices is available to me, which provides an explanation of the way in which my health information may be used or disclosed by HHS dba MVNA and of my rights with respect to my health information. **I understand I am financially responsible to HHS dba MVNA for any balance not covered by my insurance company(ies) indicated above.**

Relationship to patient: ☐ **Self OR 6 months – 18 years:** ☐ **Mother** ☐ **Father** ☐ **Other** _____
If not "self", 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.

Signature _____ **Date** _____

NURSE ONLY					
Manufacturer	**Dose**	**Age**	**Site**	**Lot number (sticker)**	**Expiration date**
FluLaval/GSK PFS	☐ 0.5 ml	☐ 6 months+	IM Deltoid: **L or R** IM Thigh (infant only): **L or R**		
Fluzone/Sanofi MDV	☐ 0.5 ml	☐ 6 months+	IM Deltoid: **L or R** IM Thigh (infant only): **L or R**		
Afluria/ Seqirus MDV	☐ 0.5 ml	☐ 3 years+	IM Deltoid: **L or R**		
HighDose/ Sanofi	☐ 0.7 ml	☐ 65 years+	IM Deltoid: **L or R**		
FluMist/ Medimmune	☐ 0.2 ml	☐ 2 to 49 years	Nasal spray		

Vaccine administrator signature _____
RN name (please print) _____ Date ___/___/2020 VIS edition ___/___/___
Vaccine Information Statement (VIS) given/offered today: ☐ (RN to check box)

Administration complete in Epic? ☐