2017-18 Millard Public Schools - Visiting Nurse Association Immunization Consent Form

Section 1 – PLEASE PRINT LEGIBLY (information for person being immunized).

LEGAL Name (Last, First, MI) | **Date of Birth** | **Age** | **Gender**

_____ **M F**

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

_____

Phone | **Email Address**

_____

Section 2 - Please select Yes or No in response to the following questions.

1. Sick or have a fever? ..... Yes No
2. Have an allergy to eggs, latex, aluminum, yeast, thimerosal or Neomycin?..... Yes No
3. Had a serious reaction to a previous dose of any vaccine?..... Yes No
4. Have any neurological problems, seizures, central nervous system disorders, Guillain-Barre'?..... Yes No
5. Pregnant or planning to be in the next 4 weeks?..... Yes No

CONSENT: I acknowledge that the medical information provided above is correct. I have been offered a paper copy or have been able to access an electronic copy of the Notice of Privacy Practices and Vaccine Information Statement, understood the risks/benefits and request that the vaccine be given to me or the person named for whom I am authorized to make this request. I understand that I/the person named, must remain on site for at least 10 minutes to be monitored for the possibility of reaction. I authorize the VNA to use this signature for consent to bill the insurance company/credit card and to authorize payment to the VNA. I understand that I will be responsible for the cost if my insurance does not cover this/these immunization(s). If above client is under 19 years, I attest that I am the child's parent or legal guardian and may provide consent for this/these immunization(s).

Individual OR Parent/Guardian Signature:

_____ **Date:** _____

Influenza Vaccine/Route:	***Dose:***	***Site:***	***Lot #:***
□ Fluarix – IM	□ 0.25mL (6-35mnths)	LD RD	
□ Fluzone – IM, □ Pres. Free	□ 0.5mL	Other:____	
□ FluLaval - IM			

Nurse Signature: Date:

Fee:_____
□ Cash
□ Check#_____
□ CC
□ Bill to Millard PS