# Influenza Vaccine

FLU

## Contact information - person being vaccinated

Last name:

First name:

Middle initial:

Gender:

Date of birth:

Street address:

City:

State:

Zip code:

Phone number:

**Immunization information** may be shared through the Minnesota Immunization Information Connection (MIIC) with other health care providers, schools, health departments, and others authorized under law to receive it. If you have any questions, please ask your health care provider. If you decide not to have this information shared with MIIC, please call 1-800-657-3970.

**Assignment of benefits and responsibilities for payment:** *This allows us to bill your health plan or company and receive payment directly.* It also means that you agree to pay for services not covered by your health plan. I authorize this health provider to bill my health plan or other payers on my behalf, and to receive payment of authorized benefits. I agree that it is my responsibility to pay for any health care services not covered by my health plan or company, including but not limited to copayments, deductibles, and co-insurance.

## Payment information

Bring a copy of your insurance card with you!

Primary insurance carrier:

Policy/ID/Member number:

Group number:

Secondary insurance carrier:

Policy/ID/Member number:

Group number:

Policy Holder, if different from vaccinee:

Name:

Date of birth:

Cash:

Company payment:

Company name:

## Agreement

I have read or had explained to me the Vaccine Information Statement “Influenza Vaccine: What You Need to Know.” I have had the chance to ask questions which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the influenza vaccination be given to me or to the person named above for whom I am authorized to make this request. I also acknowledge that a copy of the NOTICE OF PRIVACY PRACTICES has been made available to me.

Signature of Patient or Legal Guardian:

Date:

Verification:

## Health History

1. Are you (the person being vaccinated) sick today? (Fever of 100.5°F or higher on the day of the clinic)
2. Have you ever had Guillain-Barré Syndrome within 6 weeks of an influenza vaccination?
3. Do you have a severe allergic reaction (e.g., anaphylaxis) to a component of the vaccine?
4. Is this your first time receiving the flu vaccine?
5. Have you ever had a reaction to a dose of flu vaccine that needed immediate medical attention?
6. Do you have any long-term health issues such as:

Heart disease, lung disease, asthma, kidney disease, neuromuscular or neurologic disease, liver disease, metabolic disease (e.g., diabetes), anemia or other blood disorder, cancer, leukemia, HIV/AIDS or any other immune system problem; or in the past 3 months, have taken medications that weaken the immune system, such as cortisone, prednisone, other steroids, or anticancer drugs; or radiation treatments.

1. Has a health care provider ever told you that you have wheezing or asthma?
2. Has a health care provider told you that you have a spinal fluid (CSF) leak of any kind?
3. Do you have a cochlear implant?
4. Have you received a solid organ transplant (e.g., kidney, heart, lung, etc.) and taking medication that suppresses your immune system?
5. Are you pregnant?
6. Are you receiving or have you received influenza antiviral medications within the previous 48 hours for oseltamivir (Tamiflu) and zanamivir (Relenza), previous 5 days for peramivir (Rapivab), or previous 17 days for baloxavir (Xofluza)?
7. Do you take aspirin or aspirin-containing medication every day? (only for patients < 18 years of age)
8. Will you have close contact with a person hospitalized for a bone marrow transplant?
9. Have you received MMR, varicella, MMRV, or yellow fever vaccinations in the past 4 weeks?

## For Clinic Use Only - Do not write in this area

### Vaccine

### Astra-Zeneca GSK Sanofi Seqirus

### High Dose Adjuvanted

### Dose: 0.2 ml 0.25 ml 0.5 ml

### Lot #: Exp. Date:

### Vaccinator

### VIS 8/6/21 provided:

### Administered by:

### Date:

### Clinic site:

### Administration

Left Deltoid

Right Deltoid

Left Vastus Lateralis

Right Vastus Lateralis

Intranasal