FLU Influenza Vaccine

Contact Information - person being vaccinated

Last Name		Street Address	
First Name		City	
Middle I		State	
Date of Birth		ZIP	
		Phone	

Immunization information may be shared through the Minnesota Immunization Information Connection (MIIC) with other healthcare 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!

Insurance Carrier		Policy Holder, if different person	
Policy Number		Name	
Group Number		Date of Birth	
Company Paid		Cash	

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 _____

Health History

	YES	NO
1. Are you sick today? (Fever of 100.5 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 life-threatening allergy 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 of the COVID-19 symptoms on the displayed list?		
7. Have you had close contact with a COVID-19 positive person?		
8. Do you have a pending COVID-19 test?		

For Clinic Use Only - Do Not Write In This Area

Vaccine		**Vaccinator**		Administration
Astra-Zeneca GSK	Sanofi Seqirus	VIS 8/15/19 provided	☒	Left Deltoid
High Dose	Adjuvanted	Administered By:		Right Deltoid
Dose:		Date:		Left Thigh
Lot:	Exp Date:	Clinic Site:	ICNS	Right Thigh