

Last Name		First Name		M.I.	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-binary <input type="checkbox"/> Prefer not to disclose	Date of Birth	Age
Street Address			City	State	Zip Code	Phone Number	
Race and Ethnicity: <input type="checkbox"/> Alaskan Native <input type="checkbox"/> American Indian <input type="checkbox"/> Asian American <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or LatinX <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other: _____ <input type="checkbox"/> Prefer not to disclose							

INSURANCE INFORMATION

Complete the information below or attach a copy of your insurance cards to this form.

Primary Insurance Name	Policy or Member Number	Group or Account Number
Secondary Insurance Name (if applicable)	Policy or Member Number	Group or Account Number

Mark All That Apply:
 Uninsured
 Patient Payment \$ _____
 MN Care, Medical Assistance, MHCP, PMAP
 Company Payment - Company Name: _____

MEDICAL SCREENING QUESTIONS

Please answer the following questions for the person being vaccinated.	YES	NO
1. Are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever felt dizzy or faint before, during, or after a shot?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had a serious reaction after receiving a vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you, your parent, or your sibling have a nervous (e.g. brain, seizure, GBS) or immune (e.g. cancer, leukemia, HIV/AIDS) system problem?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever been diagnosed with myocarditis, pericarditis, or Multisystem Inflammatory Syndrome (MIS)?	<input type="checkbox"/>	<input type="checkbox"/>
STOP Only answer the questions below if you want FluMist. Must be Age 2-49 to qualify. *STOP*		
7. Do you have any long-term health problems (including wheezing/asthma)? Are you taking regular aspirin-containing medication, Pepto-Bismol, or Alka-Seltzer?	<input type="checkbox"/>	<input type="checkbox"/>
8. In the past 6 months, have you taken medications that affect the immune system such as steroids or anticancer drugs; drugs to treat rheumatoid arthritis, Crohn's, or psoriasis; or had radiation treatment?	<input type="checkbox"/>	<input type="checkbox"/>
9. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>
10. Are you pregnant or planning to be?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you received any vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>

SIGNATURE AND ACKNOWLEDGEMENT

I authorize Homeland Health Specialists, Inc. (HHSI) to coordinate my care with other healthcare providers. I understand that immunization information may be shared with the Minnesota Immunization Information Connection (MIIC) as authorized by law. I further authorize HHSI to bill my health plan or other payers on my behalf, which may include the program sponsor, MDH, MnVFC program, and UUAV program, and to receive direct payment for authorized services. The program sponsor may request proof of vaccination, by initialing here ____, I revoke authorization to share proof of vaccination with the program sponsor. I agree that it is my responsibility to pay for any healthcare services not covered by my health plan or the program sponsor, including but not limited to copayments, deductibles, and coinsurance. I have read and understand the current Vaccine Information Statement. I have had the opportunity to ask questions and received answers to my satisfaction. I understand the risks and benefits of the vaccination(s) and I expressly consent and authorize a nurse to administer the vaccine(s) to me. I agree to stay in the general area for 15 minutes following my vaccination. I release HHSI, all representatives of HHSI, and the program sponsor of this event from any and all damages, injuries, or adverse reactions that may result from participation in this program. I acknowledge that a copy of the NOTICE OF PRIVACY PRACTICES has been made available to me.

_____ Signature of Patient or Legal Guardian	_____ Today's Date	Staff Verification
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FOR CLINIC USE ONLY – DO NOT WRITE IN THE BOXES BELOW

Manufacturer: _____ Trade Name: _____ Dose: _____ Lot #: _____ Exp Date: _____ IM: <input type="checkbox"/> L Deltoid <input type="checkbox"/> R Deltoid <input type="checkbox"/> L Thigh <input type="checkbox"/> R Thigh FluMist Nasal Spray (Ages 2-49 only) <input type="checkbox"/> Intranasal	Manufacturer: _____ Trade Name: _____ Dose: _____ Lot #: _____ Exp Date: _____ IM: <input type="checkbox"/> L Deltoid <input type="checkbox"/> R Deltoid <input type="checkbox"/> L Thigh <input type="checkbox"/> R Thigh FluMist Nasal Spray (Ages 2-49 only) <input type="checkbox"/> Intranasal	Manufacturer: _____ Trade Name: _____ Dose: _____ Lot #: _____ Exp Date: _____ IM: <input type="checkbox"/> L Deltoid <input type="checkbox"/> R Deltoid <input type="checkbox"/> L Thigh <input type="checkbox"/> R Thigh FluMist Nasal Spray (Ages 2-49 only) <input type="checkbox"/> Intranasal
VIS DATES: VIS 8/6/21: Tdap, Influenza. VIS 5/12/23: Hep B, PCV. VIS 10/19/23: COVID-19. Dx code: Z23		VACCINATOR Administered by: _____ <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px auto;"></div>
		Date Administered and VIS provided: _____ <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px auto;"></div>