HennepinHealthcare MVNA

2019-2020 FLU VACCINE
Bill Insurance/Bill Employer
Registration Form

Clinic Number: 46305

Employer/Name of Clinic Location:

PRINT IN INK ONLY- REQUIRED INFORMATION 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 Code**

Phone Number ☐**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:

Date of Birth:

Address:

Phone:

Relationship to patient:

MVNA20190501

Payment Options:

☐ **Bill Insurance**

*Accurate & complete information below is required for successful billing

☐ **Bill Employer**

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

(#1) Primary Insurance Company Name

Primary Insurance ID#

Group #

(#2) Secondary Insurance Company Name

Secondary Insurance ID#

Group #

Policy Holder/Subscriber:

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

Policy Holder Last Name

First Name

Policy Holder Date of Birth (MM/DD/YYYY)

Daytime Phone Number ☐**Same Phone as Patient**

Policy Holder Address ☐**Same Address as Patient**

City **State** **Zip Code**

Please complete the following questions **Attention:** If you answer yes to any of the questions, further assessment is needed by the nurse.	**Form Reviewed by:**
1. Does the person to be vaccinated have any allergies to medications, egg, a vaccine component, or latex?	☐Yes ☐No
2. Has the person to be vaccinated ever had a serious reaction after receiving a vaccination?	☐Yes ☐No
3. Has the person to be vaccinated ever had Guillain-Barre Syndrome?	☐Yes ☐No
4. Has the person to be vaccinated already received the flu vaccine this flu season?	☐Yes ☐No
5. Is the person to be vaccinated presently ill with a fever, sore throat, or cough?	☐Yes ☐No
FLUMIST ONLY: Only answer #6-15 if you are interested in receiving the FluMist Nasal Spray	
6. Is the person to be vaccinated younger than 2 years old or 50 years or older?	☐Yes ☐No
7. 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?	☐Yes ☐No
8. 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?	☐Yes ☐No
9. Is the person to be vaccinated in close contact with anyone whose immune system is severely compromised?	☐Yes ☐No
10. Has the person to be vaccinated received any vaccinations in the past 4 weeks?	☐Yes ☐No
11. Is the person to be vaccinated receiving influenza antiviral medications?	☐Yes ☐No
12. Is the person to be vaccinated pregnant or you could become pregnant during the next month?	☐Yes ☐No
13. 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?	☐Yes ☐No
14. Is the Child between 2 and 4 years of age, and has been told they have wheezing or asthma in the past 12 months?	☐Yes ☐No
15. If under 18, does the person to be vaccinated receive aspirin therapy or aspirin-containing therapy?	☐Yes ☐No

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 _____, (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** _____

Signature: _____ **Date:** _____

Print Name: _____

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.

NURSE ONLY

Manufacturer	Dose	Age	Site	Lot Number (Sticker)	Expiration Date
FluLaval/GSK **Quadrivalent**	☐ 0.5 ml	☐ 6 months & up	IM Deltoid: **L or R** IM Thigh (infant only): **L or R**		
Fluzone/Sanofi **Quadrivalent**	☐ 0.5 ml	☐ 6 months & up	IM Deltoid: **L or R** IM Thigh (infant only): **L or R**		
HighDose Fluzone/ Sanofi	☐ 0.5 ml	☐ 65 years & up	IM Deltoid: **L or R**		
FluMist/ Medimmune	☐ 0.2 ml	☐ 2 to 49 years	Nasal spray		

Vaccine Administrator Signature: _____

RN Name (Please Print): _____ Date: ___/___/2019 VIS Edition: ___/___/___

Vaccine Information Statement (VIS) given/offered today: ☐ (RN to check box)

Administration complete in Epic? ☐

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