IIV

Flu shot

Influenza Vaccine

Information with **ORANGE** box or highlighted in YELLOW must be completed including Health History.

White Earth Nation HOME HEALTH

DEPARTMENT OF HEALTH

Turn Completed Form into the Health Office. *Students with an incomplete form will not receive flu vaccine.*

Contact Information - person being vaccinated

Last Name | First Name | Middle I | 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 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.* I authorize this health provider to bill my health plan or other payers on my behalf, and to receive direct payment of authorized benefits.

Insurance Information (OPTIONAL)

Are you ELIGIBLE to go to Indian Health Services (IHS)? ☐ YES ☐ NO

Primary Insurance: | Policy/ID/Member #: | Group #:

Secondary Insurance: | Policy/ID/Member #: | Group #:

Policy Holder Name, if different from vaccinee | Name: | Date of Birth:

☐ Medicare ONLY, Medicare Beneficiary Identifier (MBI) (11 digits)

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

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?

For Clinic Use Only - Do Not Write In This Box

MIIC_____ RPMS_____ Billing_____

Vaccine

☐ Private Pay ☐ MnVFC

☐ Sanofi ☐ MDV ☐ SDS

Dose: ☐ .25 ml ☐ .5 ml

Lot #: _____ Exp. Date: _____

Vaccinator

☐ VIS 8/15/19 provided

Administered by: _____

Date: _____

Administration

☐ Left Deltoid ☐ Right Deltoid

☐ Left Thigh ☐ Right Thigh