SEASONAL INFLUENZA IMMUNIZATION 2020-2021

SANFORD HEALTH

Patient Name_____ Date of Birth _____ Age _____

Address _____

City _____ State _____ Zip _____

Phone Number _____

If Patient is a minor, Parents Name _____

COPIES OF FRONT & BACK OF ALL INSURANCE CARDS REQUIRED FOR EACH PATIENT
If you are unable to provide a copy of your card, please complete below:

Insurance Company Name _____

Insurance ID _____

Insurance Group _____

Children under 9 years old
Children 6 months through 8 years of age who have not received at least two influenza vaccinations prior to this dose, are recommended to have another dose at least 4 weeks after this dose. If you are unsure if a booster is need, contact your provider.
Please schedule an appointment for the booster vaccination.

OFFICE USE ONLY
Place of Service:

☐ Hospital Outpatient	☐ Home Health
☐ Minneota Clinic	☐ School
☐ Canby Clinic	☐ Other_____

Influenza Vaccination Record (Enterprise)

Age of the person to be vaccinated: _____

Yes	No	
❑	❑	Is the person to be vaccinated sick today?
❑	❑	Is the person to be vaccinated allergic to any medications, foods, a vaccine component, or latex? List:_____
❑	❑	Has the person being vaccinated ever had a serious reaction after receiving a flu shot or FluMist?
❑	❑	Is the person to be vaccinated younger than 6 months of age?
❑	❑	Is the person to be vaccinated younger than 2 years or older than 49 years?
❑	❑	Does the patient have a long-term health problem, such as heart disease, lung disease (including asthma), kidney disease, metabolic disease (e.g., diabetes), liver disease, anemia, or another blood disorder?
❑	❑	For children age 2 years through 4 years: in the past 12 months, has a healthcare provider told the parent/ guardian the child has wheezing or asthma, or is it documented in the electronic medical record?
❑	❑	Does the patient to be vaccinated have cancer, leukemia, HIV/AIDS, or any other immune system problem; or, in the past 3 months, have they taken medications that affect the immune system, such as prednisone, other steroids, drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis or anti-cancer drugs; or have they had radiation treatments?
❑	❑	Is the person to be vaccinated receiving influenza antiviral medications?
❑	❑	Is the person to be vaccinated a child or teen age 2 years through 17 years and receiving aspirin therapy or aspirin-containing therapy?
❑	❑	Is the person to be vaccinated pregnant or could she become pregnant within the next month?
❑	❑	Has the person to be vaccinated ever had Guillain-Barré syndrome?
❑	❑	Does the patient to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?
❑	❑	Has the person to be vaccinated received any other vaccinations in the past four weeks?

Eligibility for State Funded Vaccine

Yes	No	
❑	❑	Is the child between the ages of 6 months through 18 years?
❑	❑	Is the child eligible for or enrolled in Medicaid?
❑	❑	Does the child have health insurance?
❑	❑	Is the child American Indian or Alaska Native?

PERSON RECEIVING VACCINE (please print)

Last Name | First Name | MI | DOB

Address | City | State | Zip | Phone #

I have been given a copy and have read or have had explained to me information about influenza vaccine. I had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine and request that it be given to me or the person named below for whom I am authorized to make this request.

Signature:_____ Date: _____ Time:_____ AM/PM

For Staff use only(Circle all that apply) **Date:**_____

Type of Vaccine	Dose	Manufacturer	Lot # and Expiration Date (or place sticker)	Site of Injection
Nasal Mist IM Formulations: Quadrivalent High Dose (65 and older) Flublock	0.2 mL 0.5 mL 0.7 mL	MedImmune Sanofi Pasteur GlaxoSmithKline		L R NAS Deltoid Vastus Lateralis

_____ Date: _____ Time:_____ AM/PM

Name and credentials of person administering

Statement of Financial Responsibility and Release of Information

FINANCIAL RESPONSIBILITY

I agree that I am financially responsible for all charges related to services provided by Sanford. If I have questions about my financial responsibility for Sanford's charges, or would like to see a copy of Sanford's Collection Policy; I may contact Sanford's Patient Financial Services.

Further, if I am provided health care services by a health care provider other than Sanford, while a patient within a Sanford facility or entity, I am financially responsible for all charges related to services provided by those health care providers. Sanford's billing statements will not include charges by health care providers who are independent of Sanford.

As a patient, I have given or will give Sanford Health or one of its affiliates my home phone number, mobile phone number, email address, and/or other contact information. By signing below, I agree to be contacted by Sanford Health, its affiliates, and/or a company hired by them using automatic dialing systems, recorded or artificial voice messages, text messages, emails, and/or similar methods. The purpose for these messages may include appointment reminders or other health care messages, patient feedback, surveys, marketing or promotional messages, upcoming events, unpaid balance messages, and/or other business messages.

ASSIGNMENT OF PAYER BENEFITS

I agree Sanford and my attending health care provider will bill and provide necessary health information to any Payers. "Payers" are any health care insurance, private or government health plan or insurance policy that I have or another third party that will pay the charges I have incurred. All Payers may make payments directly to Sanford and my attending health care provider. My signature on this form is my authorized signature for the filing of a claim and request for direct payment of benefits by any Payer to Sanford and my attending health care provider. I agree that unless Sanford or my attending health care provider have agreed with the Payer to accept payment from the Payer as full payment, I am responsible to pay any charges not paid by the Payer. These charges can include but are not limited to co-pays, deductibles, co-insurance amounts and charges for non-covered services.

MEDICARE BENEFICIARY REQUEST FOR PAYMENT AND ASSIGNMENT OF BENEFITS

If I am a Medicare beneficiary, I request that payment of authorized Medicare benefits be made on my behalf to Sanford and my attending health care provider for any services furnished me by Sanford and my attending health care provider, including physician services. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits for related services.

ACKNOWLEDGMENT

I have read the information above, and have had the opportunity to ask questions and have them answered to my satisfaction. If I am not the patient identified in the above label or on this form, I represent that I am authorized by law to agree to these conditions on the patient's behalf and am the authorized representative of the patient. A copy of this form is as effective and valid as the original.

_____ _____ _____

Signature of Patient or Authorized Person Date Time

Relationship to Patient (if not patient signing) _____

Influenza (Flu) Vaccine (Inactivated or Recombinant): *What you need to know*

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Influenza vaccine can prevent **influenza (flu)**.

Flu is a contagious disease that spreads around the United States every year, usually between October and May. Anyone can get the flu, but it is more dangerous for some people. Infants and young children, people 65 years of age and older, pregnant women, and people with certain health conditions or a weakened immune system are at greatest risk of flu complications.

Pneumonia, bronchitis, sinus infections and ear infections are examples of flu-related complications. If you have a medical condition, such as heart disease, cancer or diabetes, flu can make it worse.

Flu can cause fever and chills, sore throat, muscle aches, fatigue, cough, headache, and runny or stuffy nose. Some people may have vomiting and diarrhea, though this is more common in children than adults.

Each year **thousands of people in the United States die from flu**, and many more are hospitalized. Flu vaccine prevents millions of illnesses and flu-related visits to the doctor each year.

2 Influenza vaccine

CDC recommends everyone 6 months of age and older get vaccinated every flu season. **Children 6 months through 8 years of age** may need 2 doses during a single flu season. **Everyone else** needs only 1 dose each flu season.

It takes about 2 weeks for protection to develop after vaccination.

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against three or four viruses that are likely to cause disease in the upcoming flu season. Even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Influenza vaccine **does not cause flu**.

Influenza vaccine may be given at the same time as other vaccines.

3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of influenza vaccine**, or has any **severe, life-threatening allergies**.
- Has ever had **Guillain-Barré Syndrome** (also called GBS).

In some cases, your health care provider may decide to postpone influenza vaccination to a future visit.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting influenza vaccine.

Your health care provider can give you more information.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4 Risks of a vaccine reaction

- Soreness, redness, and swelling where shot is given, fever, muscle aches, and headache can happen after influenza vaccine.
- There may be a very small increased risk of Guillain-Barré Syndrome (GBS) after inactivated influenza vaccine (the flu shot).

Young children who get the flu shot along with pneumococcal vaccine (PCV13), and/or DTaP vaccine at the same time might be slightly more likely to have a seizure caused by fever. Tell your health care provider if a child who is getting flu vaccine has ever had a seizure.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5 What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff do not give medical advice.*

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's **www.cdc.gov/flu**