Print Form

INFLUENZA - ADULT (>18 YEARS)
VISITING NURSE SERVICES OF THE NORTHWEST
CONSENT TO TREAT/ ASSIGNMENT/RELEASE
King County Employees

MEDICAL HISTORY ACKNOWLEDGEMENT

I have no allergies to eggs, egg products, chicken proteins, vaccine components, latex products, or Thimerosal. I currently do not have an acute respiratory illness of a fever. I have not had a reaction to the flu vaccine in the past.

RELEASE OF INFORMATION

I authorize all VNS-NW records to be released and reviewed by an authorized representative of my third party payer or employer as required for payment. I authorize this information to be released and reviewed by any federal, state, or accrediting body or agency as required by the regulatory, licensing, or accrediting body.

NOTICE OF PRIVACY ACTS

I acknowledge that I have been offered a copy of Private Practices for VNS-NW under the Health Care Portability and Accountability Act (HIPAA).

Signature: X _____

ACKNOWLEDGEMENT

- I have been offered and have read a copy of the 2006-2007 Influenza Vaccine Information Statement prior to my vaccination. I understand all the risks and benefits involved and I have had a chance to ask questions. I may choose one or the other vaccine today or both.
- I agree to stay in the general area for 15 minutes after receiving my vaccination for assistance should any immediate reactions occur. I understand that if I experience any side effects, it will be my responsibility to follow-up with my physician at my expense. Mild reactions may include redness, swelling, or soreness at the injection site. General reactions may include fever, malaise, or muscle pain 6-12 hours after vaccination that can persist up to 1-2 days. Severe reactions may include anaphylaxis or death.
- I release VNS-NW and the venue at which the vaccine is being provided, its officers, employees, affiliates, successors, or directors from any and all liability that might arise from or in any way connected with this vaccine on behalf of my heirs, my personal representative, and me.
- I understand that if my insurance company does not pay for this vaccination, I will be billed for the service.
- **CONSENT TO RECEIVE VACCINE: I have read this consent and I authorize VNS-NW to give me a influenza vaccination.**

  X _____ _____
  Client Signature Date

- OVER -

King County Employees

COMPLETE ALL INFORMATION BELOW TO RECEIVE INFLUENZA VACCINE.

First Name **MI**

Last Name

Address Number **Street**

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

Age **Date of Birth** - - **Male** **Female**

Area Code **Telephone Number** - -

Bill insurance: (Check your insurance company)

- ☐ **Aetna**
- ☐ **Regence**
- ☐ **Pacificare**

OR:

- ☐ **Pay Cash**
- ☐ **Check Payable to VNS-NW Flu**

Insurance ID Number:

Group ID Number:

If patient is covered under the insurance of another party, please specific the name of the insured: _____ and your relationship to the insured: ☐ **Spouse** ☐ **Child** ☐ **Other: _____**

FOR CLINICAL USE ONLY - DO NOT WRITE BELOW THIS LINE

Sick today? ☐ No ☐ Yes If yes, explain:	Reaction to flu vaccine in past? ☐ No ☐ Yes If yes, explain:
Allergic to eggs/egg products/chicken/ proteins/vaccine components/latex/Thimerosal? ☐ No ☐ Yes If yes, explain:	
FLU: A B C D Lot #: E F G H	**FLU:** IM Deltoid: R L

X_____ _____

Nurse Signature Date

VNSNW2006