Homeland Health Specialists, Inc.
1621 E Hennepin Ave, Ste 230
Minneapolis, MN 55414
877-746-8060
www.homelandhealthspecialists.com

HOMELAND HEALTH SPECIALISTS

VACCINATION CONSENT for INFLUENZA

Last Name – Please print clearly	First Name	M I	☐ Male ☐ Female	Date of Birth	Age
Street Address	City	State	Zip Code	Home/ Cell Phone Number	

For Care, Payment and Operations: This allows us to coordinate your care with other healthcare providers and to bill for our services. This also allows your health plan to process your claims and provide services to you. Immunization information may be shared with the Minnesota Immunization Information Connection (MIIC) as authorized by law.

Assignment of Benefits and Responsibility for Payment: This allows us to bill your health plan or company and receive payment directly. It also means that you agree to pay for services not covered by your health plan. I authorize Homeland Health Specialists, Inc. to bill my health plan or other payers on my behalf, and to receive direct payment of authorized benefits. **I agree that it is my responsibility to pay for any health care services not covered by my health plan or company, including but not limited to copayments, deductibles and co insurance**.

Payment Information **Attach a copy of your insurance cards to the consent.**

1st Primary Insurance Carrier	Policy/ID/Member Number	Group/Account Number
2nd Secondary Insurance Carrier	Policy/ID/Member Number	Group/Account Number
☐ Cash Payment $	☐ Company Payment Company Name:	

Health History

Yes	No	
☐	☐	1. Is this your first flu shot ever?
☐	☐	2. Have you ever had a reaction to a flu vaccine that needed immediate medical attention?
☐	☐	3. Are you allergic to eggs?
☐	☐	4. Are you sick today? (Fever of 100.5 or higher on the day of clinic?)
☐	☐	5. Have you ever had Guillain-Barré syndrome (GBS)?

SIGNATURE AND ACKNOWLEDGEMENT

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 understand that I may revoke or cancel this consent in writing at any time. Revoking consent does not apply to information that has already been disclosed. I also 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

FOR CLINIC USE ONLY – DO NOT WRITE IN THE BOXES BELOW

VACCINE	VACCINATOR	ADMINSTRATION
Manufacturer: _____ Trade Name:_____ Quadrivalent Dose: _____ Lot #: _____ Expiration Date:_____ Dx code: Z23	Administered by: Date Administered and VIS provided:	**Intramuscular Injection Site** ☐ Left Deltoid ☐ Right Deltoid **For children <35 mo** ☐ Left Thigh ☐ Right Thigh **Date of VIS: 08/07/2015**