Hennepin Healthcare

2021-2022 Flu Vaccine Registration Form

Clinic # 49465 **Employer/name of clinic** Laborers Local 1091-Duluth

PRINT IN INK ONLY. *REQUIRED INFORMATION FOR PATIENT RECEIVING VACCINE.

***Last name** ***First name**

Middle name **Preferred name**

***Address** ***City**

***State** ***Zip** ***Phone** ☐ **Home** ☐ **Cell** ***Date of birth (MMDDYYYY)** ***Age**

***SSN - last 4 digits** ***Legal sex (M/F)**

What is your gender identity? (check one)

☐ Female ☐ Male ☐ Transgender female ☐ Transgender male
☐ Non-binary ☐ Two-spirit ☐ Genderqueer
☐ Prefer not to answer ☐ If not listed: _____

PARENT/GUARANTOR INFORMATION IF THE PATIENT IS UNDER 18 YEARS OF AGE

☐ Same as the policy holder (complete Policy Holder info)

☐ Other: (complete information below)

Full name _____

Date of birth _____ Legal Sex ____

Address _____

_____

Phone _____

Relationship to patient _____

*PAYMENT OPTION

☒ **Bill employer**

PLEASE COMPLETE THE FOLLOWING QUESTIONS, CHECK "YES" OR "NO." **Attention:** If you answer "yes" to any of the questions, further assessment will be needed by the nurse.	**Y**	**N**
1. Does the person to be vaccinated have any allergies to medications, eggs, or a vaccine component?		
2. Has the person to be vaccinated ever had a serious reaction after receiving a vaccine?		
3. Has the person to be vaccinated had Guillan-Barre Syndrome within 6 weeks of a flu vaccination?		
4. Has the person to be vaccinated already received the flu vaccine for this flu season?		
5. Is the person to be vaccinated presently ill with a fever, sore throat, or cough?		
6. Is the person to be vaccinated 65 years or older?		
Only answer questions 7 – 16 if you are interested in receiving the FluMist nasal spray.		
7. Is the person to be vaccinated younger than 2 years or 50 years or older?		
8. 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?		
9. 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?		
10. Is the person to be vaccinated in close contact with anyone whose immune system is severely compromised?		
11. Has the person to be vaccinated received any vaccinations in the past 4 weeks?		
12. Has the person to be vaccinated received influenza antiviral medications in the past 48 hours?		
13. Is the person to be vaccinated pregnant or you could become pregnant in the next month?		
14. 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?		
15. Is the child between 2 and 4 years of age, and has been told they have wheezing or asthma?		
16. If under 18 years, does the person to be vaccinated receive aspirin therapy or aspirin-containing therapy?		

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 Laborers Local 1091-Duluth (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'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 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

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.

Sign/print legibly _____ **Date** 10/21/2021

NURSE ONLY					
Manfacturer	**Dose**	**Age**	**Site**	**Lot number (sticker)**	**Expiration date**
FluLaval/GSK PFS	☐ 0.5 mL	☐ 6 mo +	IM Deltoid: **L** or **R** IM Thigh (infant only): **L** or **R**		
Fluarix/GSK PFS	☐ 0.5 mL	☐ 6 mo +	IM Deltoid: **L** or **R** IM Thigh (infant only): **L** or **R**		
Fluzone/Sanofi MDV	☐ 0.5 mL	☐ 6 mo +	IM Deltoid: **L** or **R** IM Thigh (infant only): **L** or **R**		
HighDose/Sanofi	☐ 0.7 mL	☐ 65 yrs +	IM Deltoid: **L** or **R**		
FluMist/Medimmune	☐ 0.2 mL	☐ 2- 49 yrs	Nasal spray		

Vaccine administrator signature _____

RN name (please print) _____ Date _____/_____/2021 VIS edition ____/____/____

EUA Vaccine Fact Sheet given/offered today: ☐ (RN to check box) Administration complete in Epic? ☐