Last name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_years Circle → Male or Female

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I agree to the following:**

1. Medicare B clients: I agree to have my insurance billed. Medicare B payment will be considered payment in full.
2. Wellmark BCBS and Aetna clients: I agree to have my insurance billed. If the insurance does not pay the whole amount, I agree to pay the difference.
3. We do not bill Medicare HMO’s or Medicaid HMO’s; you must pay the private pay cost and work with your insurance company for reimbursement.
4. I have read or seen a copy of the appropriate Vaccine Information Sheet or had the information explained to me.
5. I understand the risks of the vaccination and request that the flu shot is given to me.
6. I accept responsibility for seeking medical attention for any problems with this vaccine.
7. The person getting the shot has not had a severe allergic reaction after a previous dose of influenza vaccine and/or has no severe life threatening allergies.
8. The person being immunizeddoesn’t have a fever, isn’t moderately or severely ill, and doesn’t have COVID symptoms.
9. The person getting the shot has never had Guillain-Barre Syndrome.
10. In addition, the person getting intranasal Flumist is not pregnant or possibly pregnant, does not have a weakened immune system or does not care for an immunocompromised person, has not taken influenza antiviral medication in the previous 48 hours, and does not have underlying health conditions.

**SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Medicare # \_\_**  **Medicare Part B? Circle → Yes or No**

*You must have Part B in order for “regular” Medicare to pay for the flu shot.*

***Is the Medicare plan an HMO?*** *If so, we do not bill HMO’s, give client a receipt to bill the HMO.*

**Staple a copy of Wellmark card or BCBS/Aetna Member Id#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Group # \_\_\_\_\_\_\_\_\_\_\_\_ Insured member name\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member’s Date of Birth\_\_\_\_\_\_\_\_**

***Regular Shot (18-64); High Dose (65 and older); Flublok (18 years and older) or FluMist (18-49)***

***Private Pay $****\_\_\_\_\_\_\_\_\_* ***(circle→) Cash or Check#*** *\_\_\_\_\_\_\_\_* ***Receipt given by*** *\_\_\_\_\_ (initials)*

***Or bill to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***FOR OFFICE USE BELOW\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\* Please review or give current VIS sheet to patient.***

|  |  |  |  |
| --- | --- | --- | --- |
| **Immunization Date** | **Brand &**  **Lot #**  **(ok to use sticker)** | Dosage, Route & Site  *(circle)* | Vaccinator SignatureIRIS entry date and  initials |
|  |  | 0.5 ml IM 0.2 ml IN  0.7 ml IM  L deltoid  R deltoid |  |