Seasonal Influenza Vaccine (IIV and RIV) Administration Form 2021-2022

	Yes or No
Please state your age today ______________	
Is the person to be vaccinated sick today? (fever, nasal congestion, etc.)	Y - N
Does the person to be vaccinated have any allergies? If yes, please list ______________	Y - N
Has the person being vaccinated ever had a serious reaction to an influenza vaccine in the past?	Y - N
Has the person being vaccinated ever had Guillain-Barre Syndrome?	Y - N

Eligibility for State-Funded Vaccine (0-18 years only)

Is the child eligible for or enrolled in Medicaid?	Y - N
Does the child have health insurance?	Y - N
Is the child American Indian or Alaska Native?	Y - N
Does insurance cover this vaccine?	Y - N

Person Receiving Vaccine (Please Print)

Last Name	First Name	MI	Sex	DOB
Address			Race	Phone Number
City	State	Zip	Primary Care Physician	
Guardian's Last Name	Guardian's First Name		MI	Birth Date
Address, City, State and Zip				Relationship

Insurance Information (if billing through insurance) ☐ **Cash Pay $**______

Insurance Carrier		ID Number	Group Number
Subscriber Name	Birth Date	Phone Number	
Address	City/State	Zip Code	

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. My signature also authorizes entry of this vaccination into my Sanford electronic medical record. I agree that I am financially responsible for all charges related to services provided by Sanford. I agree Sanford and my attending health care provider will bill and provide necessary health information to any Payers.

X	Date/Time:

Signature of person to receive vaccine or authorized to make request

SANFORD HEALTH

Consent

Seasonal Influenza Vaccine (IIV and RIV) Administration Form 2021-2022

For Staff use only (Circle all that apply)

Type of Vaccine	Dose	Manufacturer	Lot # and Expiration Date (or place sticker)	Site of Injection
IM Formulations: Quadrivalent (IIV) Quadrivalent (RIV) High Dose (65+) (IIV)	0.5 mL 0.7 mL	Sanofi Pasteur GlaxoSmithKline		L R Deltoid Vastus Lateralis

_______________________________ Date: __________ Time:__________ AM/PM

Name and credentials of person administering

Sanford Health School Flu Shots

*All Fields Required

PATIENT INFORMATION:				
Patient's Full Legal Name:		Preferred Name:	DOB:	Sex:
EMERGENCY CONTACT INFORMATION:				
Name:	Relationship to Patient:	Address:	Phone: Home or Cell (Circle One)	
GUARANTOR INFORMATION (Who should receive the Sanford Statement):				
Name:		DOB:	Relationship to Patient:	Sex:
Home Address:			Phone: Home or Cell (Circle One)	
SECONDARY INSURANCE COVERAGE (IF APPLICABLE):				
Insurance Name, Address and Phone Number:		Group Number:	ID Number:	
Subscriber Name:		DOB:	Relationship to Guarantor:	Sex:
Home Address:			Phone: Home or Cell (Circle One)	

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.

Relationship to Patient:

_________ I am the Patient _________ I am the Parent/Guardian _________ I am the POA

_______________________________ _________ __________ a.m./p.m.

Signature of Patient or Authorized Person Date Time

SANFORD HEALTH

Acknowledgment of Notice of Privacy Practices

Patient's Name

____

Patient's Medical Record Number

____

Patient's Date of Birth (mm/dd/yyyy)

_____/_____/__________

(Or Affix Label)

I have received a copy of the Sanford Health Notice of Privacy Practices or it has been made available to me on Sanford Health's website at www.sanfordhealth.org/privacy-of-health.

The Notice describes how Sanford Health may use and disclose my health information.

Relationship to Patient:

_________ I am the Patient

_________ I am the Parent/Guardian

_________ I am the POA

Patient's Signature

______________________ Date __________ Time __________ am/pm

Or/By ______________________ Date __________ Time __________ am/pm

Written Acknowledgment Not Obtained

Staff member made a good faith effort to obtain written acknowledgment of receipt of the Notice of Privacy Practices but was unable to for the following reason:

- ☐ Notice Provided - Patient/Personal Representative refused to sign
- ☐ Notice Provided - Patient/Legal Representative unable to sign
- ☐ Notice Provided - Awaiting Signature

______________________ Date __________ Time __________ am/pm

Employee Signature

VACCINE INFORMATION STATEMENT

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 and older, pregnant people, 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.

In an average 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 vaccines

CDC recommends everyone 6 months 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 the influenza viruses believed to be 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 vaccination 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 until a future visit.

Influenza vaccine can be administered at any time during pregnancy. People who are or will be pregnant during influenza season should receive inactivated influenza vaccine.

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 the shot is given, fever, muscle aches, and headache can happen after influenza vaccination.
- 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 members 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. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. 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.

7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at www.fda.gov/vaccines-blood-biologics/vaccines.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)** or
  - Visit CDC's website at www.cdc.gov/flu.