Visiting Nurse Association   Date: _____   Location: _____   **ADULT**
1524 Sycamore Street
Iowa City, IA 52240
Phone: 319-337-9686   VIS**:** Flu Shot-(IIV)-8/6/21,   Pneumonia-(PPSV23)-10/30/19,   Pneumonia-(PCV13)-8/6/21

Patient Information (Please Print)

Last Name: _____   **First:**_____   **M / F / Other**

Address: _____   **City:** _____   **State:** _____   **Zip:** _____

Phone: _____   **Birthdate:**_____   **Age:** _____

Patient Consent

Special Cautions (See Vaccine Information Sheet for details)
1. If you have any of the following, obtain vaccination under your doctor's supervision
      * Have had a serious allergic reaction to eggs or a vaccine component, including Thimerosal
      *Have had previous severe reaction to flu/pneumonia shots
      *Have an active neurological disorder (delay until stabilized) or history of Guillain-Barre Syndrome
2. If you have an acute infection with fever over 100 F, delay immunization until you have recovered from illness.
3. **High Dose Influenza vaccine is for individuals aged 65 years and older to help boost immune response.**

I have read the information sheet about the influenza/pneumonia vaccine. The information I have provided above is correct and true to my knowledge. I understand the benefits and risks of the vaccination and request that the vaccine be given to me or to the person listed above, for whom I am authorized to make this request. **If insurance denies payment, or my original method of payment is rejected, I understand that I will be responsible for the unpaid balance.** I understand all information obtained by the VNA is only for treatment, payment or health operations.

                                                                                                         I authorize:
_____   _____   ____ Influenza Regular Injection
Signature of person to receive vaccine or authorized to sign   Date   ____ Influenza High Dose Injection
                                                                                                         ____ Pneumonia Injection

Payment Information (Please show insurance card to volunteer)

Medicare B: Medicare #_____ (Must have MBI or Social Security #)

Medical Insurance Company: _____Phone _____

Claims address _____

Member ID_____   Group # _____

Primary Policy Holder Name   _____

Patient relationship to policy holder: (circle one)   Self   Spouse   Child   Other

Patient Pay Full: Cash $_____   Check #_____   Amount $_____

Flu: $41 ($38 cash/check now)   High-dose Flu: $79 ($76 cash/check now)   Pneumonia: PPSV23 $145 or PCV13 $235

Voucher Payment: Voucher #_____   **Company:** _____

Company Pay: _____

To be completed by VNA Nurse

Flu Vaccine IM: L Deltoid   R Deltoid   Other _____   **Lot Number**_____

Pneumonia Vaccine IM: L Deltoid   R Deltoid   Other _____   **Lot Number**_____

***Nurse Signature** _____