XYZ HHA

Community Wellness Program 2005-2006

SCREENING QUESTIONNAIRE FOR INFLUENZA VACCINE

1. Are you 18 years or older? Yes No
2. Are you ill today? Yes No
3. Are you allergic to:
   - Thimerosal (a preservative found in some vaccines and Contact lens solutions)? Yes No
   - Eggs, egg products or chicken? Yes No
   - Latex? Yes No
   - Gelatin? Yes No
   - Other? Yes No

   ____
   Please List
4. Have you ever had an anaphylactic or neurological reaction (e.g. seizure) to a previous dose of Flu vaccine?** Yes No

   If yes, persons wishing to receive the vaccine should see their primary care physician.
5. Are you in your first trimester of pregnancy? Yes No

   Women who are currently in their first trimester of pregnancy may not receive the influenza vaccine. It is recommended that they wait until the second or third trimester. Women in their second or third trimester must receive a note from their physician indicating it is safe for them to receive an influenza vaccine.
6. Do you have an active neurological disease? Yes No

   If yes, persons wishing to receive the vaccine should see their primary care physician.
7. Have you ever had Guillain-Barre Syndrome (GBS)? Yes No

   If yes, persons wishing to receive the vaccine should see their primary care physician.
8. Do you have thrombocytopenia or a coagulation disorder? **(FOR FLUVIRON ONLY)** Yes No

   If yes, persons wishing to receive the vaccine should see their primary care physician.

** The strains included in the 2005-2006 influenza vaccine are A/New Caledonia/20/99/IVR-116 (H1N1), A/New York/55/2004/X-157 (H3N2) (anA/California/7/2004-like strain) and B/Jiangsu/10/2003 (a B/Shanghai/361/2002-like strain). Gelatin 0.05% is added as a stabilizer.

INFORMED CONSENT FORM

I have read the information on the Vaccine Information Sheet (VIS) by the Center for Disease Control about influenza and influenza vaccine. I have had an opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of influenza vaccine and request that the vaccine be given to me.

INFORMATION ABOUT PERSON TO RECEIVE A VACCINE **(PLEASE PRINT)**

Company Name or Store Name

______________________________ ______________ __________

Last Name First MI Birth Date Age

______________________________ ______________ ________ __________

Street City State Zip

______________________________ ______________

Signature of person to receive vaccine (or person authorized to make the request) Date

FOR CLINIC USE ONLY

#____________________ __#________________ ______________ ______________

Clinic Identification # | Manufacturer No., Lot No. & Exp. Date | Site of Injection | Nurse Initials

Cash Check Medicare

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MEDICARE CONSENT FORM (If billing Medicare for vaccination ONLY)

By signing this Medicare Consent for Influenza Vaccine, I agree that I carry Medicare A & B, and am **NOT** enrolled in a managed care senior health insurance plan. (For example,[here name local Medicare Advantage Plans]). I also agree to reimburse XYZ HHA $22.00 for the cost of the influenza vaccine if Medicare denies payment for the vaccine.

Insured's Medicare # (please print clearly)

____

Signature of Patient:____

Sex (circle one): Male Female

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NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

XYZ HHA is providing all patients with a notice that describes how medical information about you may be used and disclosed and how you can get access to this information. This notice meets the requirements as stipulated in the Health Insurance Portability and Accountability Act (44 CFR 165.520).

Please sign below acknowledging receipt of the *Notice of Privacy Practices for Protected Health Information.*

____________________________________ ________________________________

Signature **Date**