## 1621 E Hennepin Ave, Ste 230 Minneapolis, MN 55414 877-746-8060



## **BASIC VACCINATION CONSENT**

Street Address    City	Last Name	First Name			☐ Male ☐ Female Da		Date of Birth	Age			
Race and Ethnicity:   Alaskan Native   American indian   Asian American   Bilack or African American   Hispanic or LatinX   Prefer not to disclose   Primary Insurance Name   Prefer not to disclose   Primary Insurance Name   Primary Insurance Name   Prolicy or Member Number   Group or Account Number   Gr						′					
Race and Ethnicity:   Alaskian Native   American Indian   Asian American   Black or African American   Hispanic or LatinX   Prefer not to disclose	Ctroot Address	City	State 7in Co		7in Codo			box			
Mative Hawaiian   Pacific Islander   White   Other:   Prefer not to disclose   INSURANCE INFORMATION	Street Address	City State Zip Code Phone Number									
Mative Hawaiian   Pacific Islander   White   Other:     Prefer not to disclose											
INSURANCE INFORMATION	Race and Ethnicity:   Alaskan Native	☐ American Indian ☐ Asian American ☐ Black or African American ☐ Hispanic or Latin							nΧ		
Complete the information below or attach a copy of your insurance cards to this form.	☐ Native Hawaiian ☐							sclose			
Policy or Member Number   Group or Account Number   Secondary Insurance Name   Policy or Member Number   Group or Account Number   Secondary Insurance Name (if applicable)   Policy or Member Number   Group or Account Number    Mark All That Apply:   Uninsured   Patient Payment \$	INSURANCE INFORMATION										
Secondary Insurance Name (if applicable)    Policy or Member Number   Patient Payment \$	Complete the information below or attach a copy of your insurance cards to this form.										
Mark All That Apply:   Uninsured	Primary Insurance Name Policy or Member Number					Group or	Group or Account Number				
Mark All That Apply:   Uninsured											
Please answer the following questions for the person being vaccinated:    NEDICAL SCREENING QUESTIONS	Secondary Insurance Name (if applicable) Policy or Member Number Group or Account Number							umber			
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Please answer the following questions for the person being vaccinated:    NEDICAL SCREENING QUESTIONS	Mark All That Apply: Unincured Detect Designs to										
MEDICAL SCREENING QUESTIONS											
Please answer the following questions for the person being vaccinated.											
1. Are you sick today? 2. Have you ever felt dizzy or faint before, during, or after a shot? 3. Do you have any allergies to medications, food, a vaccine component, or latex? 4. Have you ever had a serious reaction after receiving a vaccine? 5. Do you, your parent, or your sibling have a nervous (e.g. brain, seizure, GBS) or immune (e.g. cancer, leukemia, HIV/AIDS) system problem? 6. Have you ever been diagnosed with myocarditis, pericarditis, or Multisystem Inflammatory Syndrome (MIS)? 7. Do you have any long-term health problems (including wheezing/asthma)? Are you taking regular aspirin-containing medication, Peptoblismol, or Alka-Seltzer? 7. Do you have any long-term health problems (including wheezing/asthma)? Are you taking regular aspirin-containing medication, Peptoblismol, or Alka-Seltzer? 8. In the past 6 months, have you taken medications that affect the immune system such as steroids or anticancer drugs; drugs to treat rheumatoid arthritis, Crohn's, or psoriask; or had radiation treatment? 9. In the past year, have you received amy received immune (gamma) globulin, blood/blood products, or an antiviral drug? 10. Are you pregnant or planning to be? 11. Have you received any vaccinations in the past 4 weeks? 12. SIGNATURE AND ACKNOWLEDGEMENT 13. Lauthorize Homeland Health Specialists, inc. (HHSI) to coordinate my care with other healthcare providers. I understand that immunization information may be shared with the Minnesotal muminization information (MIC) as authorized by law. I further authorize HHSI to bill my health plan or other payers on my behaff, which may include the program sponsor, MOH, MnYFC program, and UUAV program, and to receive direct payment for authorized services. The program sponsor may request proof of vaccination, by initialing here:  1. In the past of th										NO	
2. Have you ever felt dizzy or faint before, during, or after a shot? 3. Do you have any allergies to medications, food, a vaccine component, or latex? 4. Have you ever had a serious reaction after receiving a vaccine? 5. Do you, your parent, or your sibling have a nervous (e.g. brain, seizure, GBS) or immune (e.g. cancer, leukemia, HIV/AIDS) system problem? 6. Have you ever been diagnosed with myocarditis, pericarditis, or Multisystem Inflammatory Syndrome (MIS)? 75TOP* Only answer the questions below if you want FluMist. Must be Age 2-49 to qualify. *STOP* 8		person semig									
3. Do you have any allergies to medications, food, a vaccine component, or latex?  4. Have you ever had a serious reaction after receiving a vaccine?  5. Do you, you parent, or your sibling have a nervous (e.g. brain, seizure, GBS) or immune (e.g. cancer, leukemia, HIV/AIDS) system problem?  6. Have you ever been diagnosed with myocarditis, pericarditis, or Multisystem Inflammatory Syndrome (MIS)?  **TOP*** Only answer the questions below if you want FluMist. Must be Age 2-49 to qualify. **STOP**  7. Do you have any long-term health problems (including wheezing/asthma)? Are you taking regular aspirin-containing medication, Pepto-Bismol, or Alka-Seltzer?  8. In the past 6 months, have you taken medications that affect the immune system such as steroids or anticancer drugs; drugs to treat rheumatoid arthritis, Crohn's, or psoriasis; or had radiation treatment?  9. In the past 5 months, have you received immune (gammal) globulin, blood/blood products, or an antiviral drug?  10. Are you pregnant or planning to be?  11. Have you received any vaccinations in the past 4 weeks?  SIGNATURE AND ACKNOWLEDGEMENT  1 authorize Homeland Health Specialists, Inc. (HHSI) to coordinate my care with other healthcare providers. I understand that immunization information may be shared with the Minnesota Immunization Information Connection (MIIC) as authorized by law. I further authorize HHSI to bill my health plan or other payers on my behalf, which may include the program sponsor, MDH, MnVFC program, and UJAV program, and to receive direct payment for authorized services. The program sponsor may request proof of vaccination by in limiting here I revoke authorized by law. I further authorize direct payment for authorized services. The program sponsor may request proof of waccination, by in limiting here I revoke authorized by my health plan or the program sponsor, including but not limited to copayments, deductibles, and coinsurance. I have read and understand the current Vaccine information's Statement. I have had the opp	' '										
4. Have you ever had a serious reaction after receiving a vaccine?  5. Do you, your parent, or your sibling have a nervous (e.g. brain, seizure, GBS) or immune (e.g. cancer, leukemia, HIV/AIDS) system problem?  6. Have you ever been diagnosed with myocarditis, pericarditis, or Multisystem Inflammatory Syndrome (MIS)?  7. Do you have any long-term health problems (including wheezing/asthma)? Are you taking regular aspirin-containing medication, Pepto-Bismol, or Alka-Seltzer?  8. In the past 6 months, have you taken medications that affect the immune system such as steroids or anticancer drugs; drugs to treat rheumatoid arthritis, Crohn's, or psoriasis; or had radiation treatment?  9. In the past 9 months, have you taken medications that affect the immune system such as steroids or anticancer drugs; drugs to treat rheumatoid arthritis, Crohn's, or psoriasis; or had radiation treatment?  9. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug?  9. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug?  10. Are you pregnant or planning to be?  11. Have you received anny vaccinations in the past 4 weeks?  12. SIGNATURE AND ACKNOWLEDGEMENT  13. In the past (HHS) to bill my health plan or other payers on my behalf, which may include the program sponsor, MDH, MnVFC program, and UUAV program, and to receive direct payment for authorized services. The program sponsor may request proof of vaccination, by initialling here in revoke authorization to share proof of vaccination with the program sponsor may request proof of vaccination, by initialling here in revoke authorization to share proof of vaccination with the program sponsor may request proof of vaccination, by initialling here in revoke authorization to share proof of vaccination with the program sponsor may request proof of vaccination, by initialling here in revoke authorization to share proof of vaccination with the program sponsor of the received increase and the											
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IM:   L Deltoid   R Deltoid   L Thigh   R Thigh FluMist Nasal Spray (Ages 2-49 only)   Intranasal  VIS DATES: VIS 8/6/21: Tdap, Influenza. VIS 5/12/23: Hep B, PCV. VIS 10/19/23: COVID-19.  IM:   L Deltoid   R Deltoid   L Thigh   R Thigh FluMist Nasal Spray (Ages 2-49 only)   Intranasal  VACCINATOR  Date Administered and VIS provided:	I rade Name: Dose:		Irade Name: Dose: Trade Name: Dose: Dose: Lot #: Eva Date:						se:		
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5/12/23: Hep B, PCV. VIS 10/19/23: COVID-19.  Administered by:  Date Administered and VIS provided:	VIS DATES, VIS 9/6/21. The Influence VIS										
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