

**VISITING NURSE SERVICE OF GREATER RHODE ISLAND
ADULT FLU VACCINE ADMINISTRATION RECORD**

Please Print

Full name:		Telephone:
Full address:		
SSN:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:

Please provide your current insurance information so we may bill on your behalf. Complete all that apply:

Medicare Part B Number:	Blue CHiP Number:
RI Medicaid Number:	Blue Cross Number:
Other Insurance Name and ID Number:	United Health Number:

Please check yes or no for each question:

- Yes ___ No ___ Are you allergic to eggs?
 Yes ___ No ___ Are you allergic to Thimersol (an ingredient in contact lens solution), Gentamycin or other Aminoglycosides (antibiotics), and/or sulfites (preservatives in red wine)?
 Yes ___ No ___ Have you taken an antibiotic within the past 48 hours?
 Yes ___ No ___ Do you currently have a fever or severe illness?
 Yes ___ No ___ Do you have neurological disorders or have you ever had Guillain-Barré syndrome (a type of paralysis)?
 Yes ___ No ___ Have you received another vaccination within the past 14 days?
 Yes ___ No ___ Have you ever had a serious reaction to a flu shot?
 Yes ___ No ___ Are you under 18?
 Yes ___ No ___ Are you pregnant?

I have read or have had explained to me the information provided about influenza and influenza vaccine. I have had an opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of influenza vaccine and request that the vaccine be given to me or to the person named below for whom I am authorized to sign. I hereby release Visiting Nurse Service of Greater Rhode Island from any and all liability associated with the administration and potential side effects of the vaccine.

This record is evidence and/or documentation that you have received the flu vaccine and it will be filed with the Visiting Nurse Service of Greater Rhode Island. They will record what vaccine was given, when the vaccine was given, the address where the vaccine was given, the name of the company that made the vaccine, the vaccine's special lot number, the name and title of the person who gave the vaccine.

AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUESTS

I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment for authorized benefits be made to Visiting Nurse Service of Greater Rhode Island.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature on this form acknowledges that I have received a copy of the Visiting Nurse Service of Greater Rhode Island's Notice of Privacy Practices document. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Visiting Nurse Service of Greater Rhode Island and/or my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

Client / Guardian Signature: _____

For Clinic / Office Use Only

Injection Site: Right Deltoid Left Deltoid Lot

Signature / Title of Vaccine Administrator: _____ Date: _____