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

Homeland Health Specialists

BASIC VACCINATION CONSENT

Last Name	First Name	M.I.	☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to disclose	Date of Birth	Age

Street Address	City	State	Zip Code	Phone Number

Race and Ethnicity: ☐ Alaskan Native ☐ American Indian ☐ Asian American ☐ Black or African American ☐ Hispanic or LatinX ☐ Native Hawaiian ☐ Pacific Islander ☐ White ☐ Other: _____ ☐ Prefer not to disclose

INSURANCE INFORMATION

Complete the information below or attach a copy of your insurance cards to this form.

Primary 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 $_____
☐ MN Care, Medical Assistance, MHCP, PMAP ☐ Company Payment - Company Name: _____

MEDICAL SCREENING QUESTIONS

Please answer the following questions for the person being vaccinated.	YES	NO
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)?	☐	☐
STOP* 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 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 any vaccinations in the past 4 weeks?	☐	☐

SIGNATURE AND ACKNOWLEDGEMENT

I 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 UUAV program, and to receive direct payment for authorized services. The program sponsor may request proof of vaccination, by initialing here____, I revoke authorization to share proof of vaccination with the program sponsor. I agree that it is my responsibility to pay for any healthcare services not covered 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 Statement. I have had the opportunity to ask questions and received answers to my satisfaction. I understand the risks and benefits of the vaccination(s) and I expressly consent and authorize a nurse to administer the vaccine(s) to me. I agree to stay in the general area for 15 minutes following my vaccination. I release HHSI, all representatives of HHSI, and the program sponsor of this event from any and all damages, injuries, or adverse reactions that may result from participation in this program. I acknowledge that a copy of the NOTICE OF PRIVACY PRACTICES has been made available to me.

_____ _____

Signature of Patient or Legal Guardian | Today's Date

Staff Verification

FOR CLINIC USE ONLY – DO NOT WRITE IN THE BOXES BELOW

Manufacturer: _____ Trade Name:_____ Dose: _____ Lot #: _____ Exp Date: _____ **IM:** ☐ L Deltoid ☐ R Deltoid ☐ L Thigh ☐ R Thigh **FluMist Nasal Spray (Ages 2-49 only)** ☐ Intranasal	Manufacturer: _____ Trade Name:_____ Dose: _____ Lot #: _____ Exp Date: _____ **IM:** ☐ L Deltoid ☐ R Deltoid ☐ L Thigh ☐ R Thigh **FluMist Nasal Spray (Ages 2-49 only)** ☐ Intranasal	Manufacturer: _____ Trade Name:_____ Dose: _____ Lot #: _____ Exp Date: _____ **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.
Dx code: Z23

VACCINATOR

Administered by: | Date Administered and VIS provided:

Updated 6/12/2024