UPDATED 7/30/2025

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

VACCINATION CONSENT
Flu Only

Homeland Health Specialists

Last Name	First Name	M.I.	Sex Assigned at Birth ☐ Male ☐Female	Date of Birth _____/_____/_____ MM DD YYYY	Age
Street Address	City	State	Zip Code	Phone Number	

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

Insurance Information: Complete the information below **AND** attach a copy of your insurance cards to this form.

Primary Insurance Carrier	Member ID or Policy Number (including prefix)	Group Number
Secondary Insurance Carrier (if applicable)	Member ID or Policy Number (including prefix)	Group Number

Mark All That Apply: ☐ Uninsured ☐ Patient Payment $_____
☐ MN Care, Medical Assistance, MHCP, PMAP ☐ Company Payment - Company Name: _____

MEDICAL SCREENING QUESTIONS

Select vaccine(s) you are requesting: Flu Vaccine: ☐ Flu Shot (6 mo and older) ☐ FluMist (2 - 49 yrs) ☐ Senior Dose (65 yrs and older)

Please answer the following questions for the person being vaccinated.	YES	NO
Are you sick today?		
Have you ever felt dizzy or faint before, during, or after a shot?		
Do you have any allergies to medications, food, a vaccine component, or latex?		
Have you ever had a serious reaction after receiving a vaccine?		
Do you, or immediate family have a nervous (e.g. **seizure**, Guillan-Barré Syndrome, brain) or immune (e.g. cancer, leukemia, HIV/AIDS) system diagnosis?		
Have you ever been diagnosed with myocarditis, pericarditis, or Multisystem Inflammatory Syndrome (MIS)?		

Month & Year of your most recent FLU vaccination: _____/_____

STOP* Only answer the questions below if you want FluMist. Must be Age 2-49 to qualify. *STOP

	YES	NO
Do you have any long-term health problems (including asthma)? Are you taking regular aspirin-containing medication, Pepto-Bismol, or Alka-Seltzer?		
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?		
In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug?		
Are you pregnant or planning to be?		
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 and give my consent to HHSI to provide and share requested information from my medical records to and from insurance companies and my primary physician for purposes of authorization and payment. 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 assign payment directly to HHSI 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 understand that immunization information may be shared with the Minnesota Immunization Information Connection (MIIC) as authorized by law. 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 related to participation in this program, however caused, including but not limited to transmission of infection or disease. In consideration of my participation in the program, I hereby knowingly and voluntarily waive any right or cause of action of any kind whatsoever that could arise as a result thereof. I acknowledge that a copy of the NOTICE OF PRIVACY PRACTICES has been made available to me and that I have read and understand such NOTICE. HHSI reserves the right to seek medical attention in emergency situations for me if the need arises while in HHSI's care.

_____ _____
Signature of Patient, Legal Guardian, or Legally Authorized Patient Representative Today's Date

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

VIS DATES: Influenza. VIS 5/12/23: **Dx code:** Z23

Vaccine Administered by:_____ **Date Administered & VIS Provided:**_____