5008 Monument Avenue, Richmond, VA 23230
804.355.7100

Patient Information

Patient Name: ___________________________________ Date of Birth: ___________________

Address: _______________________________________ Allergies: ______________________

City: _______________________ Zip Code: ___________ Phone: ________________________

Email Address: ___________________________________ Male: ❒ Female: ❒

Can IVNA contact you in the future? _____

Primary Insurance Information

Insurance Name: ________________________________

Member ID#: ____________________________ Group #: _____________________________

Payment Options (Please Circle):

Insurance Corporate Bill

Medicare Cash/Check

Vaccine: ❒ Flu ❒ Flu HD ❒ Prevnar 13 ❒ Pneumovax 23

Patient History: Please read the questions below and answer Yes or No for the person receiving a vaccine today.

Has this person ever had a severe reaction to any vaccine, which required medical care?	
Does this person have a past history of Guillain-Barre Syndrome?	
Is this person allergic to eggs, baker's yeast, streptomycin, or neomycin?	
Does this person have fever, diarrhea, or vomiting today?	
Is this person pregnant, nursing, or planning pregnancy in the next three months?	
Has this person received any vaccinations in the past 4 weeks? **If yes, Type of Vaccine & When:**	

By signing below, I certify that I have read, or have had read to me, the information on the **back of this form** and consent to, or give consent for, the administration of the vaccine(s) marked above:

Name: (print): ____

Signature: _______________________________________Date: _____________Time:___________ AM/PM

For Office Use:

Vaccine Type: _________________Date of Vaccination: ______________ Dose of vaccination: __________
Site of Vaccination: _____________ Vaccine Manufacture & Lot Number: ____________________________
Expiration Date: ________________
Signature of Administrator of Vaccine: _____________________________

Vaccine Type: _________________Date of Vaccination: ______________ Dose of vaccination: __________
Site of Vaccination: _____________ Vaccine Manufacture & Lot Number: ____________________________
Expiration Date: ________________
Signature of Administrator of Vaccine: _____________________________

Informed Consent for Administration of Vaccine:

I have read, or have had read to me, the information in the CDC's **Vaccine Information Statement(s) (VIS)** regarding the vaccine(s) marked on the front of this form. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) I understand that if any of the conditions or risk factors listed in the VIS exists, I may be at risk of complications from the vaccine. I understand that it is recommended to stay in the area where the vaccine(s) is administered for approximately 15 minutes after administration for observation and assistance from a healthcare provider, should any immediate reaction occur. I have been instructed and understand to report any adverse event that takes place after leaving the vaccine administration area to my primary care provider. I agree to release and hold harmless IVNA its officers, directors, employees, agents and the venue at which the vaccine is being provided, its employees, officers, directors, employees, agents and/or affiliates from any and all liability arising out of or in connection with the administration of the vaccine(s) marked on the front of this form. I authorize IVNA to release any medical or other to my health care providers, Medicare, or other third-party payor necessary to effectuate care or payment, and request that payment of covered benefits be made on my behalf to IVNA, for the vaccines(s) marked on the front of this form as well as any release authorized under HIPAA. I understand that I am responsible for checking my insurance benefits and for charges not covered by my employer, Medicare or insurance.