

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: COVID-19 Vaccine: ☐ COVID (12 yrs and older) ☐ COVID (6 mo - 11 yrs) 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. <u>seizure</u> , 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)?		☐	☐
Are you currently pregnant or is there a chance you might be pregnant?		☐	☐
Month & Year of your most recent COVID vaccination: ____/____		Month & Year of your most recent FLU vaccination: ____/____	
STOP Only answer the question below if you want a COVID-19 vaccine. *STOP*		YES	NO
Do you have any conditions that put you at a higher risk for severe COVID-19? Our nurse will discuss with you if you are unsure.		☐	☐
Risk factors: _____			
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?		☐	☐
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 COVID-19 Risk factor(s) Yes ☐ / No ☐ Shared Decision	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: _____ Lot #: _____ Exp Date: _____ IM: ☐ L Deltoid ☐ R Deltoid ☐ L Thigh ☐ R Thigh
Vaccines Administered by: _____ Date Administered & VIS provided: _____ VIS DATES: VIS 1/31/25: Dx code: Z23		