YOUR SHOT DOES A LOT!

By hosting an IVNA Seasonal Flu Vaccine Clinic at your church, you show your congregation that you care about their health and the health of your community.

- Every year, flu costs businesses and employers about **$10.4 billion**[1] in direct costs for in- and out-patient hospital visits for adults. Each flu season, the U.S. workforce loses 44 million days of productivity, amounting to approximately **$16.3 billion** in lost earnings.

- IVNA is a local, nonprofit organization. **Proceeds from your clinic directly benefit your community, funding vital skilled home health care for un- and under-insured members of your community.**
- IVNA has been providing flu immunizations for your community for over 20 years. And, we make it easy! Your clinic pack comes with pre-printed flyers, consent forms and sign-ups, so the logistics are simple, and our nurse does the rest.

The following checklist should be helpful in preparing for a successful clinic:

- ❑ **Provide a comfortable and convenient** location for your flu immunization clinic. Consider the demands of space and need for privacy.
- ❑ **Communicate!** Make the flu clinic a priority. Post the date and time of the clinic on calendars, send email and voicemail messages and put a notice in the bulletin. Post flyers and the sign-up form in common places like break rooms, elevators and on bulletin boards.
- ❑ **Distribute a copy of the consent form** to people before your clinic. They can read and complete the form, ask questions, and bring the completed form to the clinic to speed up the process.

[1] Molinari NA, Ortega-Sanchez IR, Messonnier ML, et al. The annual impact of seasonal influenza in the US: measuring disease burden and costs. Vaccine. 2007; 25(27): 5086-96.

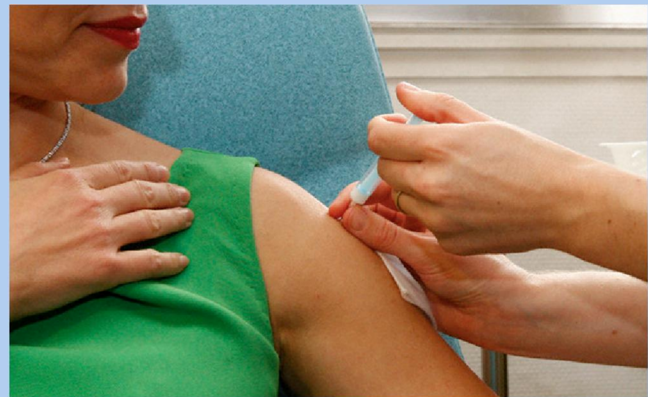
FLU CAN BE SERIOUS

Protect Yourself and Others Against the FLU.

GET VACCINATED!

If you get the flu, you can spread it to family, friends or co-workers.
Vaccination is your best protection.

Proceeds from your immunization directly benefit your community, funding vital skilled home health care for un- and under-insured members of your community.



For more information about influenza and flu vaccines, visit
www.ivna.org, or
Call the Care Clinic
804-355-7100

SEASONAL FLU SHOT CLINIC

St. Bridget Catholic Church

Sunday October 4th, 8:30-10:30am

If Insurance denies or paying by Cash/Check:
Quadrivalent Flu shot $32
High Dose Flu shot (65 and older) $54

Cash, Check, Most insurances, Medicare Part B or Medicare Replacement
(Bring a copy of your insurance card, front & back)

IVNA
INSTRUCTIVE VISITING NURSE ASSOCIATION

IVNA Flu Immunization Clinic
Sunday, October 4th, 8:30-10:30am
Sign Up for Your Immunization Below
(Please be prompt and bring all pre-filled & applicable insurance information with you)

Name	Name

VACCINATION CONSENT

Monument Corporate Centre
5008 Monument Avenue | Richmond, VA 23230
804.355.7100

Last Name ______ First Name ______ MI ______ ☐ Male ☐ Female

Address 1 ______ Address 2 ______

City ______ State ______ Zip ______ Birth Date ____/____/____

Phone (________)______ Email Address ______

Check Requested Vaccine: ☐ **Flu** ☐ **Flu HD** ☐ **Pneumonia** **CLINIC SITE:** ______

The following questions will help us determine your eligibility to receive the vaccine(s) you have requested today. ***For All Vaccines, please answer:***	Yes	No	Don't Know
Are you sick or running a fever > 100° F?			
Do you have allergies to any medications, food or vaccines? (Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, thimerosal) **If yes, please list the allergies:**			
Have you received any vaccinations in the past 4 weeks? **If yes, please list the immunization:**			
Have you ever had a serious reaction to an influenza vaccine or any other vaccine in the past?			
Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barre Syndrome (a condition that causes paralysis) or other nervous-system problem?			
Are you taking any blood-thinning medication? (ASA, Heparin, Coumadin, et al.)			
Do you have an allergy to latex?			

PAYMENT ***(please check ONE BOX and fill in all information requested):*** ☐ **Cash** ☐ **Check** ☐ **MasterCard** ☐ **Visa** ☐ **Staff** ☐ **Staff Family**

Is A Referral Required For Services? ☐ **Yes** ☐ **No**

☐ **Medicare Part B** ______
Name as it appears on card

ID # ______
Include all letters and number on card

☐ **Medicare Replacement** ______
Name of insurance company

Name as it appears on card ______

ID # ______
Include all letters and numbers on card

Group # ______
Include all letters and numbers on card

☐ **Insurance Plan Name** ______
Name of insurance company

Name as it appears on card ______

ID # ______
Include all letters and numbers on card

Group # ______
Include all letters and numbers on card

☐ **Corporate Bill** ______
Name of Company

Address ______

City ______ State ______ Zip ______

Attention ______

CONSENT:

By signing below, I certify that I have read and understand the Consent and Information Release statement on the back of this form, and have been offered and read the **Vaccine Information Statement(s) (VIS)** which explains the risks and benefits. I have had the chance to ask questions before vaccination. I understand that I am responsible for checking my insurance benefits and for charges not covered by my employer, Medicare or insurance.

Signature ______ Date ______

THIS SECTION TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY:			
	Injection Site		**Injection Site**
	L / R Deltoid IM		L / R Deltoid IM
Administered by : RN/LPN	Date Given:	Administered by: RN/LPN	Date Given:

CONSENT AND RELEASE OF INFORMATION:

I certify that I am: (a) the Patient and at least 18 years of age; (b) the legal guardian of the Patient. Further, I authorize the healthcare provider of Instructive Visiting Nurse Association (IVNA) to administer the vaccine(s) I have requested on the back of this form. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I have been offered and read a copy of the **Vaccine Information Statement(s) (VIS),** which explains the risks and benefits of the vaccine(s) I have elected to receive. I also acknowledge that I have had the chance to ask questions before vaccination, and that such questions were answered to my satisfaction.

I understand that it is recommended that, if this is a first vaccination, I will remain in the area for approximately 15 minutes after administration for observation and assistance by the administering healthcare provider, should any immediate reaction occur. I understand that, if I experience any side effects after I leave the immunization area, it is my responsibility to consult my physician at my expense.

I agree to release and hold harmless IVNA and the venue at which the vaccine is being provided, its employees, officers, directors or affiliates from any and all liability that might arise from or in any way connected with this vaccine. I authorize IVNA records to be released and reviewed by an authorized representative of my third-party payer or employer as required for payment. I also authorize this information to be released and reviewed by any federal, state or agency only as required by the regulatory or licensing body. I have been offered a copy of the **HIPPA Privacy Notice for IVNA.**

I hereby give consent for IVNA to include me on their mailing list to receive newsletters and annual mailings, and to receive a reminder for my next immunization or other upcoming wellness events.