



2017/2018 Influenza Immunization Consent Form



Name: First _____ Middle Initial _____ Last _____ M F

Address _____ Phone _____

City _____ State _____ Zip Code _____ Date of Birth _____

Insurance Carrier:

- Medicare Aetna Medicare Anthem Medicare ConnectiCare Medicare
- Aetna Anthem ConnectiCare Cigna No Insurance
- Other Insurance _____ Insurance ID # _____

Is the Insurance policy in your Name? Yes No If NO, please fill out the information below:

Name of who carries the insurance _____ Their Birth Date _____

Your Relationship to Them _____ Their Insurance ID # _____

Self Pay: Fluarix – \$20.00 Flublok – \$40.00

Check # _____ Check Date _____ Check Amount \$ _____

Please answer the following questions:

- Yes No **Have you ever had a flu shot?**
- Yes No Are you allergic to eggs or thimerosal?
- Yes No Have you ever had a serious reaction to a flu shot?
- Yes No Are you sick with a fever or are you taking an antibiotic for an infection?
- Yes No Have you ever had Guillain-Barré Syndrome?

I have read, or have had explained to me, the information sheet about influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the flu vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or Medicare HMO claim, or for other insurance purposes. **I agree that if my insurance company does not pay for the vaccine or if a co-pay or deductible applies, I will be responsible for payment.**

I acknowledge receipt of the Notice of Privacy Practices: I have had the opportunity to ask questions regarding my rights relating to the use and disclosure of my Protected Health Information (PHI).

Signature of Recipient (or Guardian): _____ Date: _____

For clinic use only HHCAH HCFX

Vaccine Type: Fluarix FluBlok Lot # _____ Exp Date _____
(Please enter appropriate vaccine type & lot number)

Injection Site: Right Arm Left Arm Pediatric Dosage: _____

Clinic Name: Middletown Town Hall – 245 deKoven Drive, Middletown, CT 06457

Nurse's signature _____ Date Admin. 2/10/2018
(Signature of Nurse and date vaccine administered)