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 – $50.00

Check # _________ Check Date ______________ Check Amount $_______________

Please answer the following questions:

❍ 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?
❍ Yes ❍ No Have you ever had a flu shot?

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: __Glastonbury Town Hall – 2143 Main Street, Glastonbury, CT 06033__

Nurse's signature _______________________________________ **Date Admin.** __1/27/2018__

(Signature of Nurse and date vaccine administered)