Hartford HealthCare at Home

2018 Influenza Immunization Consent Form

Name: First _____ **Middle Initial** _____ **Last** _____ ❍ **M** ❍ **F**

Address _____ **Phone** _____

City _____ **State** _____ **Zip Code** _____ **Date of Birth** _____

Insurance Company: **Insurance ID#** _____

❍ Medicare ❍ Aetna Medicare ❍ Anthem/BCBS Medicare ❍ ConnectiCare Medicare

❍ Aetna ❍ Anthem / BlueCross BlueShield ❍ ConnectiCare ❍ Cigna ❍ No Insurance

Who carries the health insurance? (self, parent, spouse, etc.)

Their Name _____ Their Birth Date _____

Their Insurance ID # _____ Your Relationship to Them _____

**** Please Note: If your insurance is not listed above, Self-Pay rates will apply ****

Self-Pay: ❍ Fluarix – $42.00 ❍ Flucelvax – $42.00 ❍ Flublok – $75.00

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 Nurse use only

Vaccine: ❍ **Fluarix** ❍ **Flucelvax** ❍ **FluBlok** **Lot #** _____ **Exp. Date** _____

(Please select Vaccine Name and enter Lot Number and Expiration Date)

Injection Site: ❍ **Right Arm** ❍ **Left Arm**

Clinic Location/Company Name _____

(Please clearly write name of clinic or company)

Nurse's signature _____ **Date Admin.** _____

(Signature of Nurse and date vaccine administered)