Hartford HealthCare at Home

2019 Influenza Immunization Consent Form

Name: First ____________________ **Middle Initial** _____ **Last** ____________________________ ☐ **M** ☐ **F**

Address ____ **Phone** __________________________

City ______________________________ **State** _____ **Zip Code** ________ **Date of Birth** __________

Primary Insurance Company: **Insurance ID#** ______________________________

Do not write in names – only use checkbox options below

☐ Medicare ☐ Aetna Medicare ☐ Anthem/BCBS Medicare ☐ ConnectiCare Medicare

☐ Aetna ☐ Anthem/BCBS ☐ ConnectiCare ☐ Cigna ☐ Other Insurance ☐ No Insurance

Who carries the health insurance? ☐ Self ☐ Other (parent, spouse, etc.)

Self-Pay: ☐ Flucelvax – $42 ☐ Flublok – $75 **Please Note:** If your insurance is not listed above, Self-Pay rates will apply

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: ☐ **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 print name of clinic or company as listed on Flu Schedule)

Nurse's signature ____ **Date Admin.** _________________

(Signature of Nurse and date vaccine administered)