First Choice Health Centers, Inc.
94 Connecticut Boulevard
East Hartford, Connecticut 06108
Ph:(860) 528-1359 F: (860) 528-5180

Influenza Immunization Permission
(Formulario de la vacunacion de la gripe)

First Name (Nombre): Last Name (Appellido):

Date of Birth (Fecha de Nacimiento):

Insurance (check one): _____ Private Insurance _____Uninsured _____ HUSKY/Medicaid
Sequro – (marque uno): (Sequro Privado) (No Sequro) (Sequro de Estado)

_____ SAGA _____ Medicare
(Sequro SAGA) (Medicare)

Please answer the following questions:
(Favor de contestar las siguientes preguntas):

1. _____ Yes (Si) _____ No Are you allergic to eggs?
¿Tienes alergias a los huevos?

2. _____ Yes (Si) _____ No Have you ever had a serious reaction to the flu shot?
¿Has tenido una reaccion a la vacuna de la gripe?

3. _____ Yes (Si) _____ No Are you sick with a fever?
¿Tienes fiebre?

4. _____ Yes (Si) _____ No Have you ever had Guillain-Barre Syndrome
¿Has tenido el sindrome de Guillan-Barre?

I have read, or had explained to me, the information sheet about the influenza vaccine (flu shot). I have had a chance to ask questions which were answered to my satisfaction. I understand the risks and benefits of the vaccination as described. I request that the influenza vaccine be given to me (or to the person above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process an insurance claim for this vaccine.

(He leido, o me han explicado, la informacion de la vacuna de la gripe. Tuve la oportunidad de hacer preguntas las cuales fueron contestadas a mi satisfaccion. Yo entiendo todos los riesgos y beneficios de la vacuna. Yo solicito que la vacuna de la gripe me sea administrada (o a la persona arriba mencionada a la que yo represento). Yo autorizo que se comparta toda la informacion necesaria para el proceso de cobro de esta vacuna al seguro medico.)

_____ _____
Signature of recipient (parent or guardian) Date
(Firma del paciente padre o tutor) (Fecha)

FCHC- 01/02/13