Hartford HealthCare at Home

2021 Influenza Immunization Consent Form

Please Print Legibly

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 ☐ CarePartners

Who Carries Health Insurance? Self Other Person (a parent, spouse, etc.)

Private Pay: Flucelvax $45.00 Flublok $75.00 Fluzone High Dose $75.00

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 Have you ever had Guillain-Barré Syndrome?

☐ Yes ☐ No Are you experiencing fever, muscle aches, loss of sense of smell or taste, congestion, nausea, vomiting or diarrhea or are you taking an antibiotic?

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):_____ **POA** **Date:** _____

For Nurse use only

Injection Site: ☐ Right Arm ☐ Left Arm

Vaccine: ☐ **Flucelvax** Lot # _____ Exp. Date _____

☐ **FluBlok** Lot # _____ Exp. Date_____

☐ **Fluzone** Lot#_____ Exp. Date_____

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

(Signature of Nurse and date vaccine administered)

Clinic Location/Company Name _____

(Please clearly print name of clinic or company as listed on Flu Schedule)