PHARMACY COPY

543 W. Main St. - New Britain, CT 06053 - (860) 225-6487
233 Main St. - New Britain, CT 06051 - (860) 356-3270

Influenza Vaccine Consent Form and Administration Record

Personal Information (PLEASE PRINT)

Name: ______________________ Date of Birth: ____________ Sex: M F

Address: ______________________________ City: ______________

State: ________ Zipcode: __________ Phone Number: ______________

Email: ______________________________

Screening Checklist (ADULTS & CHILDREN)	Yes	No	Don't Know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to a component of the vaccine? (ex: eggs)	☐	☐	☐
3. Has the person to be vaccinated received a flu shot in the past?	☐	☐	☐
4. Has the person to be vaccinated ever had a serious reaction to the flu shot?	☐	☐	☐
5. Has the person to be vaccinated ever had Guillain-Barre Syndrome?	☐	☐	☐

I have read or have had explained to me the Vaccine Information Statement about influenza and the influenza vaccine. I have had the chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request (parent/guardian). *[VIS Edition Date 8/6/21]*

Patient/Guardian Signature ______________________ Date ________

[if guardian, relationship to patient] ______________________

CHECK VACCINE TYPE:

Vaccine manufacturer Seqirus Fluad Quadrivalent (65 and older)
Lot #: 371597 Expiration: 5/22/24

Vaccine manufacturer Seqirus Flucelvax Quadrivalent
Lot #: 944467 Expiration: 6/26/24

Dose: 0.5 mL Route: IM

Date Administered: ______________ Location: Left Deltoid / Right Deltoid

Immunizer: ______________ Title: Intern / Pharmacist

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Insurance Information

Patient Name: ________________________________ Date of Birth: __________________________

Social Security #: ____________________________ Insurance Company: ____________________
[used for insurance billing purposes only]

Cardholder Name: ________________________________ Relationship: _____________________

Cardholder ID: ___________________________________ Rx BIN #: _______________________

PCN: _______________________ Rx Group #: __________________________

If no insurance, cost to patient is*: **Flucelvax: $51.00
Fluad: $72.99

PATIENT COPY

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Influenza Vaccine Consent Form and Administration Record

Name: ___________________________________ Date of Birth: _______________

I have read or have had explained to me the Vaccine Information Statement about influenza and the influenza vaccine. I have had the chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request (parent/guardian). *[VIS Edition Date 8/6/21]*

Patient/Guardian Signature _______________________________________ Date ________

[if guardian, relationship to patient] _______________________________

Vaccine Manufacturer: Seqirus Flucelvax Quadrivalent
Lot #: _______ Expiration: _________
Dose: 0.5 mL Route: IM

Date Administered: _________________________ Location: Left Deltoid / Right Deltoid

Immunizer: ________________________________