Central CT Health District Influenza Record-- Children Under 9 Years Old

Child's Name ____________________________ Child's Date of Birth _____________ Male Female

Street _____________________________________Town ____________________ Phone__________________

Insurance: Aetna Anthem Cigna Connecticare United Healthcare Cash

Insurance ID #_______________________ Insured's Name ________________________________

Answer the following questions:

1. If your child is between 6 months and 8 years of age, has your child received at least 2 doses of flu vaccine before July 2017?
   YES NO

2. Is the child allergic to eggs or thimerosol?
   YES NO

3. Has the child ever had a serious reaction to a flu shot?
   YES NO

4. Is the child sick with a fever?
   YES NO

5. Has the child ever had Guillain-Barre Syndrome?
   YES NO

6. Is the child currently receiving radiation, chemotherapy, or immunosuppressive therapy?
   YES NO

I have read or had explained to me the information sheet about influenza vaccination and the agency's privacy policy. I have had a chance to ask questions which were answered to my satisfaction and I understand the benefits and risks of the vaccination as described. I request that the influenza vaccine be given to me (or to the person named above for whom I am authorized to make this request). I authorize the release of any medical information necessary to process an insurance claim, payment, or for other public health purposes. I understand if my insurance does not fully cover the fee for this vaccination, I will be billed and I will pay the Central CT Health District. This authorization expires 12 months from the date below.

X________________________________ _________________

Parent's or guardian's signature Clinic Date

Clinic Use Only	Provider Name: Central Connecticut Health District Provider Tax ID Number: 06-1456781 DX Code: V04.81	Fluarix Quadravalent 0.5mL PFS Site of Injection: Deltoid ___Left ___Right Initials: _______ Location: B N R W Date ___________________