Central CT Health District -- SEASONAL INFLUENZA IMMUNIZATION RECORD

Please answer the following questions and sign below at the X.

Are you allergic to eggs? ☐ Yes ☐ No
Have you ever had a serious reaction to a flu shot? ☐ Yes ☐ No
Are you sick with a fever? ☐ Yes ☐ No
Have you ever had Guillain Barre Syndrome? ☐ Yes ☐ No

First Name
Last Name
Address
City
ST
Zip
Phone
Sex
Date of Birth

(Check the correct Insurance Co.)

☐ Aetna
☐ Anthem
☐ CIGNA
☐ Connecticare
☐ Healthy CT
☐ United Healthcare
☐ Cash $_______

☐ Is this a MEDICARE Plan?

ID#

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's name

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 that if my insurance does not fully cover the fee for this vaccination that I will be billed and that I will pay the Central CT Health District. I understand that no one will be denied vaccination for flu because of an inability to pay. This authorization expires 12 months from the date below.

X **Signature** ______________________________ **Clinic Date** ______________

Clinic Use Only
Provider Name: Central CT Health District
Provider Tax ID Number: 06-1456789
Fluarix Quadravalent 0.5mL PFS
Site: DELTOID __ L __ R
B N R W
Initials: _____

We're curious...

How did you hear about this clinic?

☐ I've been to these clinics before
☐ Flyer/Poster
☐ TV/Radio
☐ Friend
☐ Facebook
☐ Newspaper
☐ Announcement/telephone call
☐ Other ____________________