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

Are you sick with a fever? ☐Yes ☐No

Have you ever had a serious reaction to a flu shot? ☐Yes ☐No

Have you ever had Guillain Barre Syndrome? ☐Yes ☐No

Have you received a pneumonia vaccination? ☐Yes ☐No , If yes, was it Prevnar 13? ☐Yes ☐No ☐Don't know

First Name | Last Name

Address

City | State | Zip

Phone | Sex | Date of Birth

☐ Cash
☐ Aetna Commercial
☐ Aetna Medicare
☐ Anthem Commercial
☐ Anthem Medicare
☐ CIGNA Commerical
☐ CIGNA Medicare
☐ Connecticare Commercial
☐ Connecticare Medicare
☐ United Healthcare Medicare
☐ Medicare Part B

Please have your insurance card out and ready to be verified

ID#

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 Lot# 359MH

Site: DELTOID __ L __ R

B N R W

Initials: _____

How did you hear about this clinic?

☐ Flyer/Poster
☐ TV
☐ Friend
☐ Online
☐ Newspaper
☐ Announcement/telephone call
☐ Other _____