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: □Anthem #_____ □ Connecticare #_____ □ Cash

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 2016?
   □ 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 CPT Code: 90658

Fluarix Quadravalent 0.5mL PFS Lot# 359MH

Site of Injection: Deltoid ___Left ___Right Initials: _____

Location: B N R W Date _____