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
☐
☐ 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 _____