Connecticut River Area Health District
Influenza Immunization Consent Form 2022/2023 FLU SEASON

Vaccinee First Name | MI | Last Name | **Vaccinee Birthdate**

Street and Number | City | State | Zip Code

Cell Phone#_____ Sex: ☐ Male ☐ Female

YOUR DOCTOR'S NAME / PRACTICE:_____

Are you the Primary Insurance Subscriber: ☐ YES ☐ NO (If NO plese list Primary Suscriber)

Primary Subscriber: First Name_____**LastName**_____**DOB**_____

INSURANCE TO BE USED

☐ ANTHEM BC/BS ☐ CONNECTICARE ☐ CIGNA ☐ UNITED/OXFORD

☐ MEDICARE ☐ ANTHEMBC/BS MEDICARE ☐ AETNA

☐ CIGNA MEDICARE ☐ UNITED HEALTH MEDICARE

☐ CONNECTICARE MEDICARE

☐ HUSKY ☐ OTHER* ☐ NO INSURANCE*

***If you have other or no insurance the Fee is $35.00 ($65.00 for the 65yo+ High Dose)**

IF INSURED YOU MUST BRING YOUR **INSURANCE CARD(S) AND A PHOTO ID.**

Are You Allergic to Latex?	☐ NO	☐ YES
Are you Allergic to eggs or Thimerosal?	☐ NO	☐ YES
Have you ever had a serious reaction to a flu shot?	☐ NO	☐ YES
Have you ever had Guillain Barre Syndrome?	☐ NO	☐ YES
Are you sick with a fever?	☐ NO	☐ YES
Are you pregnant?	☐ NO	☐ YES
Have you ever had breast surgery or axilla lymph node removal?	☐ NO	☐ YES

INFLUENZA CONSENT: *I have read or had explained to me, the Vaccine Information Statement about influenza* ***CDC VIS*** *vaccination. 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 flu vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for other public health purposes.* ***UNDER 18 must be accompanied by a parent/guardian.***

_____

Signature of Recipient (or parent or guardian) Today's Date

OFFICE USE ONLY

Injection Site: _____Left Arm _____Right Arm Manufacturer & Lot #: _____

Nurse(Vaccinator)_____ Date of Vaccination_____

Type of Payment: N/A_____ Cash_____ Check#_____ Amount Paid:_____ Staff Initials:_____