# 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**

**INSURANCE TO BE USED**

_______ ANTHEM BC/BS ________CONNECTICARE _______CIGNA _______ UNITED HEALTH

________MEDICARE ________ANTHEMBC/BS MEDICARE

________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:______