Connecticut River Area Health District Clinic_____

Influenza Immunization Consent Form Date_____

PLEASE PRINT CLEARLY!!

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

Street and number Apt# City State Zip Code

Sex(Male/Female) Phone#

WHAT IS YOUR PRIMARY MEDICAL INSURANCE?:_____

YOUR DOCTOR'S NAME OR NAME OF PRACTICE:_____

TOWN PRACTICE IS IN:_____

INSURANCE: _____ AnthemBC/BS _____Connecticare ____CIGNA ____ UNITED HEALTH

_____Medicare _____AnthemBC/BS Medicare _____Connecticare Medicare

_____CIGNA Medicare _____UNITED HEALTH MEDICARE _____HUSKY _____Other

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

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 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.

_____

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

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

Nurse(Vaccinator) Signature Date

CONTINUED ON BACK

_____Medicare

Middle Initial: _____

Medicare Number: _____*Include letter that follows the number

Does client have Medicare Part B? _____Yes _____No

If the answer to the above question is No, Medicare will not pay for the flu shot. Do you have any other medical insurance?

If not Medicare, check insurance of primary subscriber:

_____Anthem BC/BS _____CIGNA _____Other

_____Medicare BC/BS _____Medicare CIGNA

_____Connecticare _____Medicare Connecticare

Primary subscriber:

Name: _____DOB_____

Subscriber ID Number:_____

Group Number:_____

Vaccinee's Relationship to primary subscriber:_____

Is address of primary subscriber the same as vaccinee? _____Yes _____No

If not, list address of primary subscriber:

Street & Number: _____Apt #:_____

City, State, Zip Code: _____

_____Is the Doctor's Name and address filled out on the front of this form?