WESTPORT WESTON HEALTH DISTRICT
INFLUENZA VACCINE PERMISSION 2016-2017

Received by:

PRINT CLEARLY

_____ _____ **Age _____ ☐ Male ☐Female**
Patient's Name as it appears on your Insurance card **Date of Birth**

_____ **(____)**_____
Address **City** **Zip** **Phone**

For Insurance purposes, last 4 digits of your SS# _____ Method of payment:☐ Cash_____ ☐Check#_____

We Accept only the following insurance plans: ***(Please circle your choice)***

Medicare B ***Aetna*** ***Anthem BC*** ***Cigna*** ***ConnectiCare*** ***VFC***

PROVIDE ***a copy of your Insurance card for one of the above.***

Name of Primary Card Holder: _____ ***Date of Birth :*** _____

Have you ever had a flu vaccination? …….…….. ☐ Yes ☐ No
Have you ever had a serious reaction from a previous flu vaccination? ……..... ☐ Yes ☐ No
Are you sick or do you have a fever today? …….…….... ☐ Yes ☐ No
Are you severely allergic to eggs, gentamicin, gelatin, argine or latex? ……..… ☐ Yes ☐ No
Are you allergic to thimerosal (mercury-derived preservative)? ……..…. ☐ Yes ☐ No
Do you have/ had Guillain-Barre Disease? ……..……... ☐ Yes ☐ No
Have you ever fainted or experienced dizziness following a vaccination?…… ☐ Yes ☐ No
Are you pregnant? ……..…. ☐ Yes ☐ No
(The CDC recommends that pregnant women get a flu shot during any trimester of their pregnancy to protect themselves, their developing babies, and newborn babies from the flu.)

I have read, or had explained to me, the information sheet about the Influenza Vaccine. I have had a chance to ask questions which were answered to my satisfaction and I understand the benefits and risks of the vaccination. I request that the vaccine be given to me (or the person named below, for whom I am authorized to make this request).

Health information may be disclosed for the following purposes: a) to bill and receive payment for the flu vaccine you have received; and/or b) to report any adverse reaction you may experience after receiving the flu vaccine. *I authorize release of any medical or other information necessary to process an insurance claim.* ***I understand that if the insurance rejects payment for this vaccination that the health district will bill me and I agree to pay the fee.***

_____ _____
Signature of Recipient (or Parent or Guardian) Date

FOR CLINIC USE ONLY

Clinic Site: _____ Date Vaccinated: _____

Manufacturer & Lot Number: _____ Exp. Date: _____

Injection Site: ☐ Left Arm ☐ Right Arm ☐ Left Thigh ☐ Right Thigh

Dosage (circle one): 0.25cc OR 0.5cc OR High Dose

Vaccinator's Signature: _____