

WESTPORT WESTON HEALTH DISTRICT
INFLUENZA VACCINE PERMISSION 2017-2018

Received by: _____

PRINT CLEARLY

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

Address City Zip (_____) _____
Phone

Method of payment: Cash _____ Check# _____

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

Medicare B Aetna 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: _____