Received by:

WESTPORT WESTON HEALTH DISTRICT
INFLUENZA VACCINE PERMISSION 2018-2019

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#________** ☐ **Insurance (see below) ________**

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

Medicare B ***Aetna*** ***Cigna*** ***ConnectiCare*** ***VFC***

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-Barré 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. Live vaccines are contraindicated during pregnancy.)

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): Intranasal 0.2mL OR Quadrivalent 0.25cc OR 0.5cc OR High Dose

Vaccinator's Signature: ____________________________