WESTPORT WESTON HEALTH DISTRICT
INFLUENZA VACCINE PERMISSION 2019-2020

PRINT CLEARLY

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

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

_____
Email

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 received and read a copy of the Influenza Vaccine Information Sheet (VIS) dated 8/15/2019…….. ☐ Yes ☐ No

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: _____