WESTPORT WESTON HEALTH DISTRICT
INFLUENZA VACCINE PERMISSION 2020-2021

PRINT CLEARLY

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

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

_____ _____
Email **Allergies**

Method of payment: ☐ Cash_____ ☐ **Check#**_____ ☐ **Insurance (see below)** _____

We accept only the following insurance plans: ***(Please circle your choice and include insurance information).***

Medicare B ***Aetna*** ***Cigna*** ***ConnectiCare*** ***VFC*** ***Medicaid/Husky***

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

Policy #_____ ***Group #***_____ ***Issued Date:*** _____

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.***

_____
Name of Recipient (or Parent or Guardian)

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