WESTPORT WESTON HEALTH DISTRICT
INFLUENZA VACCINE PERMISSION 2021-2022

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*** ***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 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 8/06/2021............ ☐ **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 0.2 mL OR Quadrivalent 0.25 mL OR 0.5 mL OR High Dose

Vaccinator's Signature: ____