ASPETUCK HEALTH DISTRICT
INFLUENZA VACCINE CONSENT 2022-2023

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

_____ (____)_____
Address City Zip Phone

Email_____

**CT Wiz is Connecticut's Immunization system that stores your vaccine history. May we submit your vaccination history and administration to CT Wiz? _____Yes _____No*
If no, we can help you send a signed written request to the Connecticut Department of Health.

Race (please circle): 1. White 2. Black or African American 3. Asian 4. American Indian or Alaska Native 5. Native Hawaiian or Pacific Islander

Ethnicity (please circle): 1. Hispanic 2. non-Hispanic

Preferred Language: _____

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: _____ *Birthdate of Primary Card Holder:* _____

*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