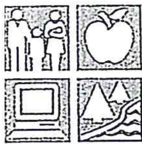

ASPETUCK HEALTH DISTRICT
INFLUENZA VACCINE CONSENT 2022-2023

______________________________ ______________ Age ______ ☐ Male ☐ Female

Patient's Name as it appears on your insurance card Date of Birth

____ (____)______________

Address City Zip Phone

Email______________________________

CT Wiz is the CT Department of Health's Immunization system that stores your vaccine history. As required by law to protect your health, we share vaccine information with CT Wiz. To exclude your vaccine information from CT Wiz you can send a signed written request to the Connecticut Department of Health, 410 Capitol Avenue, MS # 11 MUN, Hartford, CT 06134-0308 or call 860-509-7929

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

Patient's Name:______________________________ DOB:_______________

FOR CLINIC USE ONLY

Clinic Site: (circle one) 1. AHD 2. Weston Senior Center 3. Easton Library 4. Westport Center for Senior Activities

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 Standard Quad 0.5 mL OR High Dose Quad 0.7 mL

Vaccinator's Signature: ____