



2018-2019 Influenza Vaccination Consent

PLEASE PRINT CLEARLY

Last Name		First Name	
Street Address	Town	Zip Code	
Phone #	Date of Birth	Age	Sex
Email Address			

Method of Payment: Insurances that are accepted: Medicare Part B, ConnectiCare, Aetna, Cigna, Anthem BC/BS. Other forms of payment accepted are cash or check.

Insurance (Fill out insurance info below)

Cash or Check

Medicare Plans:

Non-Medicare Plans:

Insurance ID# (primary insurance):

- | | |
|--|--|
| <input type="checkbox"/> Medicare Part B | <input type="checkbox"/> ConnectiCare (non-Medicare) |
| <input type="checkbox"/> Medicare ConnectiCare | <input type="checkbox"/> Anthem BC/BS (non-Medicare) |
| <input type="checkbox"/> Medicare Anthem BC/BS | <input type="checkbox"/> Aetna (non-Medicare) |
| <input type="checkbox"/> Medicare Aetna | <input type="checkbox"/> Cigna (non-Medicare) |
| <input type="checkbox"/> Medicare Cigna | <input type="checkbox"/> Husky A, B,C,D |

Insurance - Please bring a copy of each individual insurance card, BOTH FRONT AND BACK to clinic.

All questions pertain to the person to be vaccinated today:	YES	NO
1. Do you have an allergy to eggs or any component of the flu vaccine?		
2. Have you ever had a serious reaction to the flu vaccine?		
3. Are you sick or have a fever?		
4. Have you had any other vaccinations in the past four weeks?		
5. Ever been diagnosed with the paralyzing neuromuscular disease Guillain-Barre Syndrome?		
6. Are you pregnant? <i>Intranasal Mist is available for nursing mothers.</i>		
7. Do you have a history of asthma, diabetes or any other auto-immune disease?		

I have received a copy of the Influenza Vaccine Information Statement (VIS 8/7/2015)

Patient or Parent Signature: _____ **Date:** _____

To Be Completed by Administering Nurse:

Manufacturer, Lot Number & Expiration Date:

Injection given: .25 ml IM Pediatric 0.5 ml IM Highdose IM Nasal Mist

Site Administered: RD LD RT LT

Nurse Signature

Date