

Connecticut River Area Health District
Influenza Immunization Consent Form

PLEASE PRINT CLEARLY!!

Vaccinee First Name MI Last Name Birthdate

Street and number Apt# City State Zip Code

Sex(Male/Female) Phone#

WHAT IS YOUR PRIMARY MEDICAL INSURANCE?: _____

YOUR DOCTOR'S NAME: _____

YOUR DOCTOR'S ADDRESS: _____

INSURANCE: ___ AnthemBC/BS ___ Connecticare ___ CIGNA ___ Aetna
___ Medicare ___ AnthemBC/BS Medicare ___ Connecticare Medicare
___ Aetna Medicare ___ CIGNA Medicare ___ HUSKY ___ Other

If Other, please describe: _____

Type of Payment: Cash _____ Check# _____ Amount Paid: _____ Staff Initials: _____

Are You Allergic to Latex? ___ NO ___ YES
Are you Allergic to eggs or Thimerosal? ___ NO ___ YES
Have you ever had a serious reaction to a flu shot? ___ NO ___ YES
Have you ever had Guillain Barre Syndrome? ___ NO ___ YES
Are you sick with a fever? ___ NO ___ YES
Are you pregnant? ___ NO ___ YES
Have you ever had breast surgery or axilla lymph node removal? ___ NO ___ YES

INFLUENZA CONSENT: I have read or had explained to me, the Vaccine Information Statement about influenza vaccination. I have had a chance to ask questions which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the flu vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for other public health purposes.

Signature of Recipient (or parent or guardian)

Today's Date

Injection Site: ___ Left Arm ___ Right Arm Manufacturer & Lot #: _____

Nurse(Vaccinator) Signature

Date

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____ Medicare

Middle Initial: _____

Medicare Number: _____ *Include letter that follows the number

Does client have Medicare Part B? _____ Yes _____ No

If the answer to the above question is No, Medicare will not pay for the flu shot. Do you have any other medical insurance?

If not Medicare, check insurance of primary subscriber:

____ Anthem BC/BS _____ CIGNA _____ Other

____ Medicare BC/BS _____ Medicare CIGNA

____ Connecticare _____ Aetna

____ Medicare Connecticare _____ Medicare Aetna

Primary subscriber:

Name: _____ DOB _____

Subscriber ID Number: _____

Group Number: _____

Vaccinee's Relationship to primary subscriber: _____

Is address of primary subscriber the same as vaccinee? _____ Yes _____ No

If no, list address of primary subscriber:

Street & Number: _____ Apt #: _____

City, State, Zip Code: _____

____ Is the Doctor's Name and address filled out on the front of this form?