FAIRFIELD HEALTH DEPARTMENT

INFLUENZA VACCINE PERMISSION 2021 - 2022

Patient's Name _____ **Date of Birth** _____ **Age** _____

Address _____ **Town/City** _____ **Zip** _____

Phone: _____ **Male** □ **OR** **Female** □

Circle one: **Self Pay** **Medicare B** **Aetna** **Anthem BC** **Cigna** **Connecticare** **United Healthcare** **Oxford**

Insurer's Member ID Number: _____

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 severely allergic to eggs? …… □ **Yes** □ **No**

Do you have/had Guillain-Barre Disease? …… □ **Yes** □ **No**

Is this your first visit to the Fairfield Health Department Flu Clinic? …… □ **Yes** □ **No**

I have read, or had explained to me, the information sheet about the Influenza Vaccine dated 08/06/2021. 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 Fairfield Health Department will bill me and I agree to pay the fee.***

_____ _____

Signature of Recipient (or Parent or Guardian) **Date**

FOR CLINICAL USE ONLY

_____ **GlaxoSmithKline FluLaval Quadrivalent Lot # 9ZC32 Exp 6/30/22**

_____ **Sanofi Pasteur FluZone Quadrivalent High Dose Lot # UJ764AA Exp 6/30/22**

_____ **GlaxoSmithKline FluLaval Quadrivalent Lot # 2E43L Exp 6/30/22**

Circle Injection Site: Left Arm Right Arm Dosage: 0.5cc

Vaccinator's Signature: _____ **Date:** _____