Connecticut River Area Health District

Influenza Immunization Consent Form

PLEASE PRINT CLEARLY!!

Clinic_____

Date_____

Vaccinee First Name | MI | Last Name | **Vaccinee Birthdate**

Street and number | Apt# | City | State | Zip Code

Sex (Male/Female) | Phone#

WHAT IS YOUR PRIMARY MEDICAL INSURANCE? _____

Please answer the following:

1. Is this your first flu shot EVER Yes / No
2. Have you ever had a SERIOUS reaction to a flu shot Yes / No
3. Are you sick today Yes / No
4. Do you have an allergy to an ingredient of this vaccine Yes / No
5. Have you ever had Guillian-Barre Syndrome Yes / No
6. Have you ever felt dizzy or faint before, during or after a shot Yes / No
7. Are you anxious about getting a shot today Yes / No
8. Do you have any questions for your nurse Yes / No

Consent:

I request that the influenza vaccination be given to me (or the person named above for whom I am authorized to make this request). HIPAA & VIS: I have read or had explained to me, the Vaccine Information Statement (VIS) about influenza vaccination and the Connecticut River Area Health District privacy. 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 understand that ALL vaccines administered at the CRAHD are recorded in the state vaccine database, CTWIZ.

Right to refuse: I understand that the CRAHD has the right to refuse to vaccinate anyone if the CRAHD, its agents, or employees deem that in their discretion the minor or anyone with them is uncooperative and by attempting to vaccinate could lead to a safety issue for the vaccinator, the minor or others in the vicinity. Billing consent: I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim. I understand that if my insurance rejects payment for this vaccination the CRAHD will bill me and will agree to pay the fee.

PLEASE PRESENT A PHOTO ID AND ALL INSURANCE CARDS TO BE PHOTOCOPIED. THANK YOU!

Signature of Recipient (or parent or guardian) Today's Date_____

Injection Site: _____Left Arm _____Right Arm Manufacturer & Lot #: _____

Nurse (Vaccinator) Signature Date