FAIRFIELD HEALTH DEPARTMENT

INFLUENZA VACCINE PERMISSION 2023 - 2024

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

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

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

Circle one: Aetna Anthem BC Cigna Connecticare Meritain Health Medicare

United Healthcare (Oxford) United Healthcare Other:_____

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

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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 # T3C47 Exp 06/30/2024 Dosage: 0.5cc**

Circle Injection Site: Left Arm Right Arm

Vaccinator's Signature: _____ Date: _____