



2023-2024 Influenza Vaccination Consent

PLEASE PRINT CLEARLY

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

Method of Payment: Insurances that are accepted: Medicare Part B, ConnectiCare, Aetna, Cigna, Anthem BC/BS. **WE DON'T ACCEPT ANY FORM OF UNITED HEALTHCARE.** 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 |

PLEASE MAKE A COPY OF BOTH FRONT AND BACK OF INSURANCE CARD AND ATTACH.

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 not recommended for pregnant women.</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 8/6/2021)

Patient or Parent Signature: _____ Date: _____

If Under 18 Please Print Parent/Caregiver Name: _____

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

Please Check Race & Ethnicity

Race:

Ethnicity:

<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Hispanic or Latino
<input type="checkbox"/> Asian	<input type="checkbox"/> Not Hispanic or Latino
<input type="checkbox"/> Black or African-American	
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	
<input type="checkbox"/> Other Race	
<input type="checkbox"/> White	