

Central CT Health District -- SEASONAL INFLUENZA IMMUNIZATION RECORD

Please answer the following questions and sign below at the X.

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| Are you allergic to eggs or Thimerosal? <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever had a serious reaction to a flu shot? <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever had Guillain Barre Syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you sick with a fever? <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you currently receiving radiation, chemotherapy or immunosuppressive therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No |

First Name	Last Name	
Address		
City State Zip		
Phone	Sex	Date of Birth

<input type="checkbox"/> Cash <input type="checkbox"/> Medicare Part B <input type="checkbox"/> Anthem <input type="checkbox"/> Connecticut Commercial Plan <input type="checkbox"/> Connecticut Medicare Advantage	Please show insurance card
ID# 	

I have read or had explained to me the information sheet about influenza vaccination and the agency's privacy policy. 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 influenza vaccine be given to me (or to the person named above for whom I am authorized to make this request). I authorize the release of any medical information necessary to process an insurance claim or for other public health purposes. I understand that if my insurance does not fully cover the fee for this vaccination that I will be billed and that I will pay the Central CT Health District.

X Signature _____ **Clinic Date** _____

Clinic Use Only	Provider Name: Central CT Health District Provider Tax ID Number: 06-1456789 DX Code: V04.81 CPT Code: _____	___Fluvirin ___Afluria ___Flu Mist Site: DELTOID ___Left ___Right B N R W Initials: _____ Date _____
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