Pomperaug District Department of Health
Seasonal Influenza Vaccine Administration Record (2017-18)
For Persons 6 months and Older

Please Print Clearly

Last Name		First Name			M.I.
Street Address		Town		State	Zip Code
Phone #	Date of Birth	Age	Gender ☐ Male ☐ Female	If under 10 years old, weight:	
Email Address					

Method of Payment: *Insurance that is accepted: Medicare Part B, ConnectiCare, Aetna, Cigna, Anthem BC/BS, and HUSKY for* ***children*** *to 18 years. All others must pay by cash, check, or credit card.*
Insurance that is NOT accepted: Access Health CT / CT Exchange plans (gold, silver bronze) UnitedHealthcare & others not listed above.

☐ **Cash • Check • Credit Card**
☐ **Insurance (Fill out insurance info below)**

Medicare Plans:
- ☐ **Medicare Part B**
- ☐ **Medicare ConnectiCare**
- ☐ **Medicare Anthem BC/BS**
- ☐ **Medicare Aetna**
- ☐ **Medicare Cigna**

Non-Medicare Plans:
- ☐ **ConnectiCare (non-Medicare)**
- ☐ **Anthem BC/BS (non-Medicare)**
- ☐ **Aetna (non-Medicare)**
- ☐ **Cigna (non-Medicare)**
- ☐ **HUSKY A, B, C, D** (for **children** 6 mos. – 18 yrs.)

Insurance ID # *(primary insurance)*

Subscriber Name

Check Vaccine Preference:
- ☐ **Quadrivalent Vaccine** (ages 6 months & older) (the "regular" flu shot)
- ☐ **High Dose Vaccine** (optional choice for age 65 & older)
- ☐ **Flublok Vaccine** (any adult 18 yrs. & older; suitable for persons with egg allergy)

Fill out this section and sign on the day of the clinic

For PDDH Use Only
☐ **VFC**
Attach Eligibility Form
☐ Cash
☐ Ins
☐ NF

Please Answer The Following Four Questions

☐ Yes ☐ No Is person sick or does person have a fever?
☐ Yes ☐ No Has person ever had a serious reaction to a flu shot?
☐ Yes ☐ No Any allergies to eggs, thimerosal, or other components of the vaccine?
☐ Yes ☐ No Has person ever had Guillain-Barré Syndrome?

I have read or had explained to me the Vaccine Information Statement (VIS 8/7/2015) about seasonal influenza and the influenza vaccine. I have had a chance to ask questions and I understand the benefits and risks of the influenza vaccine. I request that the 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 or other information necessary to process an insurance claim. I have read and agree to the Pomperaug Health District's privacy policy. I understand that if my insurance does not fully cover the fee for this vaccination that the Pomperaug Health District may bill me for the balance of the fee.

Signature ______________________________ ***Date*** ________________

Print Name if Parent or Guardian ______________________________

For Clinic Use

Vaccine Manufacturer & Lot #:

Dose: ☐0.5ml IM **Site:** ☐LD ☐RD ☐LT ☐RT
For child 6m – 8yr: 2nd dose required in 28 days ☐No ☐Yes & Parent informed
Administered by: __________ Date: ____________