Pompperaug District Department of Health
Seasonal Influenza Vaccine Administration Record (2019-20)
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: *We accept: Medicare Part B, Aetna, Cigna, UnitedHealthcare, HUSKY/Medicaid, and ConnectiCare and Anthem BC/BS (with the exception of their Access Health CT / CT Exchange plans - gold, silver, bronze)*

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

Medicare Plans:
- ☐ Medicare (Part B)
- ☐ Medicare ConnectiCare
- ☐ Medicare Anthem BC/BS
- ☐ Medicare Aetna
- ☐ Medicare Cigna
- ☐ Medicare UnitedHealthcare

Non-Medicare Plans:
- ☐ ConnectiCare (non-Medicare)
- ☐ Anthem BC/BS (non-Medicare)
- ☐ Aetna (non-Medicare)
- ☐ Cigna (non-Medicare)
- ☐ UnitedHealthcare (non-Medicare)
- ☐ HUSKY / Medicaid

Insurance ID # *(Primary Insurance)*

Subscriber Name

Check Vaccine Preference:
- ☐ **Quadrivalent** (ages 6 mo. & up) (regular flu shot)
- ☐ **FluMist** (nasal spray; healthy persons age 2-49 yrs.)
- ☐ **High Dose** (optional for age 65 & older)
- ☐ **Flublok** (adult 18 yrs. & older)

Please answer the following five questions for the person receiving vaccination:

☐ Yes ☐ No **Is person receiving the flu vaccine between 6 months – 8 years of age?**

If YES, to above question: Did the child receive at least 2 doses of any influenza vaccine before July 1, 2019? (Doses need not have been received during the same or consecutive seasons.) ☐ ***Yes*** ☐ ***No*** ☐ ***Unknown***

If NO or UNKNOWN, child needs 2 doses for 2019-20, at least 4 weeks apart.

☐ *Yes* ☐ *No* **Is person sick or does person have fever on the day the person is receiving the flu vaccine?**

☐ Yes ☐ No **Any allergies to eggs / or thimerosal?**

☐ Yes ☐ No **Ever had Guillain-Barré Syndrome?**

☐ Yes ☐ No **Ever had an allergic reaction after a flu vaccination or have any other severe life-threatening allergies?**

For Clinic Use
☐ **VFC**
Attach Eligibility Form

If receiving FluMist, please answer additional questions for the person receiving the vaccination:

☐ Yes ☐ No **Received any vaccine in the past 4 weeks?**

☐ Yes ☐ No **Child 2-4 years old with asthma or an episode of wheezing in the past 12 months?**

☐ Yes ☐ No **Cares for a person who has severely compromised immune system who requires a protected environment?**

☐ Yes ☐ No **Pregnant or nursing?**

☐ Yes ☐ No **Receiving influenza antiviral medication in past 48 hours (all ages) OR receiving aspirin (age 2-17 yrs.)?**

☐ Yes ☐ No **Have a weakened immune system OR an underlying medical condition (i.e. asthma, lung disease, heart disease, kidney or liver disorder, neurologic or neuromuscular disorder, diabetes or metabolic disorder) that increases risk of serious flu complications?**

I have read or had explained to me the Vaccine Information Statement (VIS 8/15/2019) 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

Dose: ☐0.5ml IM **Site:** ☐LD ☐RD ☐LT ☐RT ☐0.2ml intranasal

Administered by: ______________ Date: ______________

Vaccine Manufacturer & Lot #