Pomperaug District Department of Health
Seasonal Influenza Vaccine Administration Record (2020-21)

Please Print Clearly

Last Name		**First Name**			**M.I.**
Street Address	**Town**		**County**	**State**	**Zip Code**
Phone #	**Date of Birth**	**Age**	**Gender** ▭ Male ▭ Female		**If under 10 years old, weight:**
Email Address					
For Persons Under 19 Years, name of Parent(s) or Legal Guardian(s)					

Method of Payment: ***See reverse side for accepted insurance plans.***
MUST present insurance cards for person listed above – ID numbers may be different for each individual.
We reserve the right to refuse service if card is not presented.

▭ **Medicare Insurance** ▭ **Non-Medicare Insurance** **OR** ▭ **Cash • Check • Credit Card**

Check Name of Insurance Plan

- ▭ **Medicare (Part B)**
- ▭ **ConnectiCare**
- ▭ **Anthem BC/BS**
- ▭ **Cigna**
- ▭ **Aetna**
- ▭ **UnitedHealthCare**
- ▭ **Oxford - UnitedHealthcare**
- ▭ **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)

▭ Yes ▭ No Do you need proof of vaccination for work / volunteering / school?

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, Did the child receive at least 2 doses of any influenza vaccine before July 1, 2020? (Doses need not have been received during the same or consecutive seasons.) ▭***Yes*** ▭***No*** ▭***Unknown***
If NO or UNKNOWN, child needs 2 doses for 2020-21, at least 4 weeks apart.

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

▭ *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?**

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 medical condition that increases risk of serious flu complications (i.e. asthma, lung/heart disease, kidney/liver disorder, neurologic/neuromuscular disorder, diabetes/metabolic disorder, no spleen, cochlear implant, cerebrospinal fluid leak)?**

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*** _____

For Clinic Use

Dose: ▭0.5ml IM ▭0.7 ml IM **Site:** ▭LD ▭RD ▭LT ▭RT ▭0.2ml intranasal

Administered by: _____ Date: _____

Vaccine Manufacturer & Lot #

Pomperaug District Department of Health

The insurance cards for <u>each</u> individual receiving a flu shot must be presented.

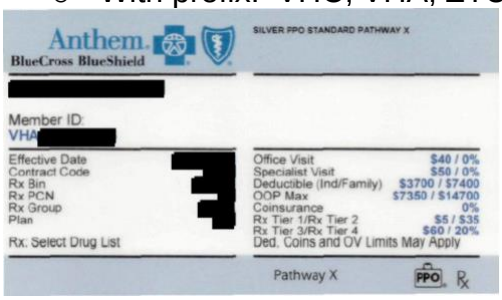
The following health insurance plans are accepted:

- **Medicare Part B**
- **Connecticare**
  - Medicare plan
  - Commercial plans
    - <u>With the exception of</u> AccessHealthCT / CT Exchange plans*
- **Anthem Blue Cross & Blue Shield**
  - Medicare plan
  - Commercial plans
    - <u>With the exception of</u> AccessHealthCT / CT Exchange plans*
- **Aetna**
  - Medicare plan
  - Commercial plans
- **Cigna**
  - Medicare plan
  - Commercial plans
- **United HealthCare**
- **Oxford - United HealthCare**
- **HUSKY plans & Medicaid**

Plans other than those listed above are not accepted.

***The following plans ARE NOT accepted:**

- Platinum, Gold, Silver, Bronze Plans
- Anthem BC&BS AccessHealthCT or CT Exchange plans
  - With prefix: VHC, VHA, ZTU, VJW, VHE, or VHF



- ConnectiCare AccessHealthCT or CT Exchange plans