



# 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	If under 10 years old, weight:	
<input type="checkbox"/> Male <input type="checkbox"/> Female					
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**

- |  |  |
|--|--|
| <input type="checkbox"/> Medicare (Part B) | <input type="checkbox"/> Aetna                     |
| <input type="checkbox"/> ConnectiCare      | <input type="checkbox"/> UnitedHealthCare          |
| <input type="checkbox"/> Anthem BC/BS      | <input type="checkbox"/> Oxford - UnitedHealthcare |
| <input type="checkbox"/> Cigna             | <input type="checkbox"/> HUSKY / Medicaid          |

*Insurance ID # (Primary Insurance)*

*Subscriber Name*

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

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  
 CVP  
 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 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 each individual receiving a flu shot must be presented.

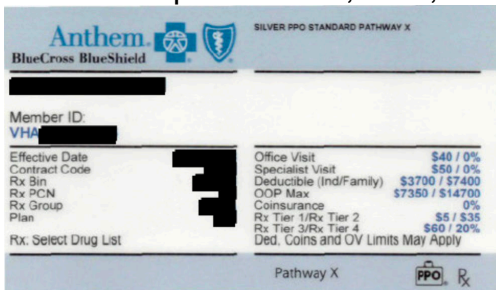
## The following health insurance plans are accepted:

- **Medicare Part B**
- **Connecticare**
  - Medicare plan
  - Commercial plans
    - With the exception of AccessHealthCT / CT Exchange plans\*
- **Anthem Blue Cross & Blue Shield**
  - Medicare plan
  - Commercial plans
    - With the exception of 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

