2020-2021 Influenza Vaccination Consent

Remember to wear a mask and maintain 6 foot distance

PLEASE PRINT CLEARLY

Method of Payment: Insurances that are accepted: Medicare Part B, ConnectiCare, Aetna, Cigna, Anthem BC/BS. **WE DON’T ACCEPT ANY FORM OF UNITED HEALTHCARE.** Other forms of payment accepted are cash or check.

☐ Insurance (Fill out insurance info below)  ☐ Cash or Check

Medicare Plans:  Non-Medicare Plans:  Insurance ID# (primary insurance):

☐ Medicare Part B  ☐ ConnectiCare (non-Medicare)
☐ Medicare ConnectiCare  ☐ Anthem BC/BS (non-Medicare)
☐ Medicare Anthem BC/BS  ☐ Aetna (non-Medicare)
☐ Medicare Aetna  ☐ Cigna (non-Medicare)
☐ Medicare Cigna  ☐ Husky A, B,C,D

PLEASE MAKE A COPY OF BOTH FRONT AND BACK OF INSURANCE CARD AND ATTACH.

All questions pertain to the person to be vaccinated today:

1. Do you have an allergy to eggs or any component of the flu vaccine?

2. Have you ever had a serious reaction to the flu vaccine?

3. Are you sick or have a fever?

4. Have you had any other vaccinations in the past four weeks?

5. Ever been diagnosed with the paralyzing neuromuscular disease Guillain-Barre Syndrome?

6. Are you pregnant? *Intranasal Mist is not recommended for pregnant women.*

7. Do you have a history of asthma, diabetes or any other auto-immune disease?

☐ I have received a copy of the Influenza Vaccine Information Statement (VIS 8/15/2019)

Patient or Parent Signature: ____________________________ Date: _____________

If Under 18 Please Print Parent Name: ______________________________

To Be Completed by Administering Nurse:

Manufacturer, Lot Number & Expiration Date: __________________

Injection given:  ☐ .25 ml IM Pediatric  ☐ 0.5 ml IM  ☐ Highdose IM  ☐ Nasal Mist

Site Administered:  ☐ RD  ☐ LD  ☐ RT  ☐ LT

_____________________________  ________________________
Nurse Signature  Date

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