2020 Influenza Immunization Consent Form

Name: **First** _____ **Middle Initial** _____ **Last** _____ ☐ **M** ☐ **F**

Address _____ **Phone** _____

City _____ **State** _____ **Zip Code** _____ **Date of Birth** _____

Primary Insurance Company: **Insurance ID#** _____

Do not write in names – only use checkbox options below

☐ Medicare ☐ Aetna Medicare ☐ Anthem/BCBS Medicare ☐ ConnectiCare Medicare

☐ Aetna ☐ Anthem/BCBS ☐ ConnectiCare ☐ Cigna ☐ Other Insurance ☐ No Insurance

Who carries the health insurance? ☐ Self ☐ Other Person (a parent, spouse, etc.)

Please answer the following questions:

Temperature _____

☐ Yes	☐ No	**Have you ever had a flu shot?**
☐ Yes	☐ No	Are you allergic to eggs or Thimerosal?
☐ Yes	☐ No	Have you ever had a serious reaction to a flu shot?
☐ Yes	☐ No	Have you ever had Guillain-Barré Syndrome?
☐ Yes	☐ No	Are you experiencing, fever, muscle aches, loss of sense of smell or taste, congestion, nausea, vomiting or diarrhea or are you taking an antibiotic?

I have read, or have had explained to me, the information sheet about influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the flu vaccination be given to me (or 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 a Medicare or Medicare HMO claim, or for other insurance purposes**. I agree that if my insurance company does not pay for the vaccine or if a co-pay or deductible applies, I will be responsible for payment.**

I acknowledge receipt of the Notice of Privacy Practices: I have had the opportunity to ask questions regarding my rights relating to the use and disclosure of my Protected Health Information (PHI).

Signature of Recipient (or Guardian): _____ **Date:** _____

For Nurse use only

Vaccine: ☐ **Flucelvax** ☐ **FluBlok** **Lot #** _____ **Exp. Date** _____

(Please select Vaccine Name and enter Lot Number and Expiration Date)

Injection Site: ☐ Right Arm ☐ Left Arm

Clinic Location/Company Name University of Hartford

(Please clearly print name of clinic or company as listed on Flu Schedule)

Nurse's signature _____ **Date Admin.** _____

(Signature of Nurse and date vaccine administered)