Stratford Health Department ~ 468 Birdseye Street ~ Stratford CT 06615 ~ (203) 385-4058

INFLUENZA IMMUNIZATION CONSENT FORM

Last Name:
First Name:
Address:
City:
Zip:
Primary Phone Number:
DOB (mm/dd/yyyy):
Age:
Sex:

Please Answer the Following Questions:	YES	NO
Are you allergic to eggs?		
Have you ever had a serious reaction to a flu shot?		
Have you ever had Guillain Barre Syndrome?		
Are you sick with a fever?		
Are you pregnant?		

Primary Insurance:
Insurance Company:
ID #:
Secondary Insurance:
Insurance Company:
ID#:
I understand that if my insurance denies payment, then I will be billed for these services. X____ ***Signature of recipient (or parent/guardian)***

Influenza Injection Consent:
I have read, or had explained to me, the information sheet about influenza vaccination and the Stratford Health Department's privacy policy. I have had a chance to ask questions which were answered to my satisfaction and I understand the benefits and risks of the vaccination as described. I request that the influenza 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 other insurance claim.

X_________________________________ _____________
Signature of recipient (or parent/guardian) ***Date***

FOR STAFF ONLY:	
Vaccine Site: ☐ Left Arm ☐ Right Arm	
Manufacturer:	
Lot #:	**Exp. Date:**
X_____________________________ ***Nurses Signature***	_______________ ***Date***
VIS Form Given: ☐	

Self Pay: Cash or Check	**Total**	
Flublok	$70.00	
Drug Code	90686	90682
Administrative Code	G0008	90471
Diagnosis Code	Z23	