FAIRFIELD HEALTH DEPARTMENT

INFLUENZA VACCINE PERMISSION 2023 - 2024

______________________________ ____________ ________
Patient's Name **Date of Birth** **Age**

______________________________ ____________
Address **Town/City** **Zip**

Phone/Email: ______________________________ **Male □ OR Female □**

Circle one: **Aetna** **Anthem BC** **Cigna** **Connecticare** **Meritain Health** **Medicare**

United Healthcare (Oxford) **United Healthcare** **Other:**__________________

Insurer's Member ID Number: ______________________________

Have you ever had a flu vaccination? ……………………………………………………	**□ Yes**	**□ No**
Have you ever had a serious reaction from a previous flu vaccination? …………	**□ Yes**	**□ No**
Are you sick or do you have a fever today? ……………………………………………	**□ Yes**	**□ No**
Are you severely allergic to eggs? ………………………………………………………..	**□ Yes**	**□ No**
Do you have/had Guillain-Barre Disease? ………………………………………………..	**□ Yes**	**□ No**
Is this your first visit to the Fairfield Health Department Flu Clinic? ……………..	**□ Yes**	**□ No**

I have read, or had explained to me, the information sheet about the Influenza Vaccine dated 08/06/2021. I have had a chance to ask questions which were answered to my satisfaction and I understand the benefits and risks of the vaccination. I request that the vaccine be given to me (or the person named below, for whom I am authorized to make this request).

Health information may be disclosed for the following purposes: a) to bill and receive payment for the flu vaccine you have received; and/or b) to report any adverse reaction you may experience after receiving the flu vaccine. *I authorize release of any medical or other information necessary to process an insurance claim.* ***I understand that if the insurance rejects payment for this vaccination that the Fairfield Health Department will bill me and I agree to pay the fee.***

______________________________ ______________
Signature of Recipient (or Parent or Guardian) **Date**

FOR CLINICAL USE ONLY

__________ **GlaxoSmithKline FluLaval Quadrivalent Lot # T3C47 Exp 06/30/2024 Dosage: 0.5cc**

__________ **Fluzone Quad High Dose 0.7mL Lot # U8138BA Exp. 06/30/2024 Dosgae: 0.7mL**

__________ **GlaxoSmithKline FluLaval Quadrivalent Lot # 2XT9D Exp 06/30/2024 Dosage: 0.5cc**

Circle Injection Site: Left Arm Right Arm

Vaccinator's Signature: ______________________________ **Date:** ______________