FAIRFIELD HEALTH DEPARTMENT

INFLUENZA VACCINE PERMISSION 2020 - 2021

____ ______________ ________
Patient's Name **Date of Birth** **Age**

____ ____________
Address **Town/City** **Zip**

Phone: _________________________ **Male □ OR Female □**

Circle one: **Self Pay** **Medicare B** **Aetna** **Anthem BC** **Cigna** **Connecticare** **United Healthcare**

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 8/15/2019. 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

_________ **Sanofi Pasteur Fluzone Quadrivalent Lot # UT7081KA Exp 6/30/21**

_________ **Sanofi Pasteur Fluzone High Dose Exp 6/30/21**

Circle Injection Site: **Left Arm** **Right Arm** **Dosage:** **0.5cc**

Vaccinator's Signature: ___________________________________ **Date:** _________________