**INFLUENZA VACCINE CONSENT FORM**

Patient’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_ Age:\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Town: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent name if under 18: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pediatrician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Town: \_\_\_\_\_\_\_\_\_\_

**Please answer the following:**

Is this your first flu shot **EVER**? Yes / No

Have you ever had a **SERIOUS** reaction to a flu shot? Yes / No

Are you sick today? Yes / No

Do you have an allergy to an ingredient of this vaccine? Yes / No

Have you ever had Guillian-Barre Syndrome? Yes / No

Have you ever felt dizzy or faint before, during or after a shot? Yes / No

Are you anxious about getting a shot today? Yes / No

Do you have any questions for your nurse? Yes / No

**Consent:**

I request that the influenza vaccination be given to me (or the person named above for whom I am authorized to make this request).

* **HIPAA & VIS:** I have read or had explained to me, the Vaccine Information Statement (VIS) about influenza vaccination and the \_\_\_\_\_\_\_\_ Health Department’s privacy. 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 understand that ALL vaccines administered at the \_\_\_\_\_\_\_ Health Department are recorded in the state vaccine database, CtWiz.
* **Right to refuse:** I understand that the \_\_\_\_\_\_\_ Health Department has the right to refuse to vaccinate anyone if the \_\_\_\_ Health Department, its agents, or employees deem that in their discretion the minor or anyone with them is uncooperative and by attempting to vaccinate could lead to a safety issue for the vaccinator, the minor or others in the vicinity.
* **Billing consent:** I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim. **I understand that if my insurance rejects payment for this vaccination the \_\_\_\_\_\_\_ Health Department will bill me *and* will agree to pay the fee.**

**PLEASE PRESENT A PHOTO ID AND ALL INSURANCE CARDS TO BE PHOTOCOPIED. THANK YOU!**

**X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of recipient (or parent or guardian)**

Scan here for a copy of the VIS.

Place sticker here: Right

Left

Ask at the front desk if you would like a different language.



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**Nurse Signature Date**