



2020-2021 Influenza Vaccination Consent

Remember a mask and 6 foot distance

PLEASE PRINT CLEARLY

Last Name		First Name	
Street Address		Town	Zip Code
Phone #	Date of Birth	Age	Sex
Email Address		Physician	

Method of Payment: Insurances that are accepted: Medicare Part B, ConnectiCare, Aetna, Cigna, Anthem BC/BS. **WE DON'T ACCEPT ANY FORM OF UNITED HEALTHCARE.** Other forms of payment accepted are cash or check.

Insurance (Fill out insurance info below)

Cash or Check

Medicare Plans:

Non-Medicare Plans:

Insurance ID# (primary insurance):

Medicare Part B

ConnectiCare (non-Medicare)

Medicare ConnectiCare

Anthem BC/BS (non-Medicare)

Medicare Anthem BC/BS

Aetna (non-Medicare)

Medicare Aetna

Cigna (non-Medicare)

Medicare Cigna

Husky A, B,C,D

**PLEASE MAKE A COPY OF BOTH
FRONT AND BACK OF
INSURANCE CARD AND ATTACH.**

All questions pertain to the person to be vaccinated today:	YES	NO
1. Do you have an allergy to eggs or any component of the flu vaccine?		
2. Have you ever had a serious reaction to the flu vaccine?		
3. Are you sick or have a fever?		
4. Have you had any other vaccinations in the past four weeks?		
5. Ever been diagnosed with the paralyzing neuromuscular disease Guillain-Barre Syndrome?		
6. Are you pregnant? <i>Intranasal Mist is not recommended for pregnant women.</i>		
7. Do you have a history of asthma, diabetes or any other auto-immune disease?		

I have received a copy of the Influenza Vaccine Information Statement (VIS 8/15/2019)

Patient or Parent Signature: _____ Date: _____

If Under 18 Please Print Parent Name: _____

To Be Completed by Administering Nurse:

Manufacturer, Lot Number & Expiration Date:

Injection given: .25 ml IM Pediatric 0.5 ml IM Highdose IM Nasal Mist

Site Administered: RD LD RT LT

Nurse Signature

Date