Pomperaug District Department of Health
Seasonal Influenza Vaccine Administration Record (2014-15)
For Persons 3 years and Older

You may print out a blank form and fill it out (please print legibly) OR you may type into the fields & checkboxes and print it out.

Last Name	First Name	M.I.

Street Address	Town	State	Zip Code

Phone #	Date of Birth	Age	Sex	If under 18 years old, weight:
			☐ Male ☐ Female	

Method of Payment: *Insurances accepted: Medicare (Part B), ConnectiCare, Aetna, Cigna, Anthem BC/BS. All others must pay by cash, check, or credit card. Insurance **NOT** accepted: UnitedHealthcare & other insurance.*

☐ **Insurance (Fill out insurance info below)** ☐ **Cash/Check/Credit Card**

Check primary insurance carrier below:

- ☐ **Medicare Part B**
- ☐ **Medicare ConnectiCare**
- ☐ **Medicare Anthem BC/BS**
- ☐ **Medicare Aetna**
- ☐ **Medicare Cigna**
- ☐ **ConnectiCare (non-Medicare)**
- ☐ **Anthem BC/BS (non-Medicare)**
- ☐ **Aetna (non-Medicare)**
- ☐ **Cigna (non-Medicare)**

Insurance ID # *(primary insurance)*

Check Vaccine Preference:

- ☐ **High Dose Injectable** (shot; 3 vaccine strains; optional for age 65 & older)
- ☐ **Injectable** (shot; 4 vaccine strains; for ages 6 months & older)
- ☐ **FluMist** (nasal spray; 4 vaccine strains; for healthy persons ages 2-49 yrs. only)

Please Answer The Following Four Questions

- ☐ Yes ☐ No Is person sick or does person have a fever?
- ☐ Yes ☐ No Has person ever had a serious reaction to a flu shot?
- ☐ Yes ☐ No Any allergies to eggs or thimerosal (a preservative)?
- ☐ Yes ☐ No Has person ever had Guillain-Barré Syndrome?

For PDDH Use Only
☐ **VFC** Attach Eligibility Form
☐ Cash ☐ Ins ☐ NF

If receiving FluMist (nasal spray), please answer these additional questions:

- ☐ Yes ☐ No Has person received any vaccine in the past 4 weeks?
- ☐ Yes ☐ No Is the person under 5 years old with an episode of wheezing in the past year?
- ☐ Yes ☐ No Any allergies to gelatin, gentamicin or arginine?
- ☐ Yes ☐ No Does anyone living with the person have a severely compromised immune system?
- ☐ Yes ☐ No Is the person pregnant?
- ☐ Yes ☐ No Is the person receiving long-term aspirin therapy (age 18 years & under)?
- ☐ Yes ☐ No Does person have a long-term health condition (i.e. asthma, heart disease, diabetes, seizure disorder, cerebral palsy), a weakened immune system due to AIDS/HIV or other disease that affects immune system?

I have read or had explained to me the Vaccine Information Statement (VIS 2014-2015) about seasonal influenza and the influenza vaccine. I have had a chance to ask questions and I understand the benefits and risks of the influenza vaccine. I request that the vaccine be given to me or to 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 an insurance claim. I have read and agree to the Pomperaug Health District's privacy policy. I understand that if my insurance does not fully cover the fee for this vaccination that the Pomperaug Health District may bill me for the balance of the fee.

Signature _____ ***Date*** _____

Print Name if Parent or Guardian _____

For Clinic Use ***Vaccine Manufacturer & Lot #:***

Dose: ☐0.5ml IM ☐0.2ml intranasal ☐0.25 IM
For child 6m – 8yr, 2nd dose required in 28 days ☐No ☐Yes & Parent informed
Site: ☐LD ☐RD ☐LT ☐RT Administered by: _____ Date: _____