



STAFF USE

CT State Clinic

Clinic Site: _____

Verified by: _____

**CONNECTICUT STATE CLINICS
2013 ADULT INFLUENZA IMMUNIZATION CONSENT**

Patient Name (As it appears on insurance card)		Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth ____/____/____	Age: _____
Address: <i>No. and Street Name (No PO Box Please)</i>		City	State	Zip
Home or Cell Phone: _____		Work Phone: _____		

PRIMARY INSURANCE INFORMATION: Please check your insurance; fill in your insurance ID# and policyholder's name.

<p>CONNECTICUT STATE INSURED EMPLOYEES ONLY</p> <p><input type="checkbox"/> Anthem CT State Plan</p> <p><input type="checkbox"/> Oxford CT State Plan</p> <p><input type="checkbox"/> Other _____</p>	<p>Insurance ID <input type="text"/></p> <p>Name of insured person if other than patient: _____</p>
--	---

PLEASE ANSWER THE FOLLOWING QUESTIONS

1. Have you had a severe allergic reaction (including but not limited to hives) to eggs, latex or the preservative thimerosal?
If yes, circle which one. Yes No
2. Have you ever had a reaction to any vaccine? If yes, which vaccine. _____ Yes No
3. Have you ever been diagnosed with Guillain-Barré Syndrome? Yes No
4. Are you sick with a fever of >100 degrees today? Yes No

UNDER AGE 50 ONLY: Answer the following ONLY if you are interested in receiving FLUMIST.

- A. Do you have chronic health issues such as: diabetes; heart, lung, kidney or liver disease; COPD or asthma, or a neuromuscular/neurological diseases? Yes No
- B. Are you in close contact with an immunosuppressed person who requires protective isolation? Yes No
- C. Are you pregnant or is there a chance you might be pregnant? Yes No
- D. Have you taken an antiviral medication such as Tamiflu® or Relenza® within the last 48 hours? Yes No
- E. Have you been immunized with a live vaccine (MMR, chicken pox, shingles, yellow fever or oral typhoid) within the past 4 weeks? Yes No

I have read the Influenza Vaccine Information Statement dated 07/26/2013. I have had a chance to ask questions and I understand the benefits and risks of the vaccine. I request that the vaccination be given to me (or to the person for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process the insurance claim or for other public health purpose. I have read the Notice of Privacy Practices. I agree to pay all unpaid charges billed to me by Western Connecticut Home Care.

Signature: _____ Print Name: _____

STAFF USE ONLY

<i>Place vaccine label here or complete:</i> Vaccine Brand: _____ Lot #: _____ Exp. Date: _____			
<input type="checkbox"/> Standard	<input type="checkbox"/> FluMist	<input type="checkbox"/> T-Free	<input type="checkbox"/> High Dose
Site: <input type="checkbox"/> L Arm <input type="checkbox"/> R Arm <input type="checkbox"/> Intranasal	Administered by: _____	Date: ____/____/____	