



Clinic Site: \_\_\_\_\_

Verified by: \_\_\_\_\_

CONNECTICUT STATE CLINICS  
2014 ADULT INFLUENZA IMMUNIZATION CONSENT

Patient Name (As it appears on insurance card)	Gender	Date of Birth	Age: _____
	<input type="checkbox"/> M <input type="checkbox"/> F	____/____/____	

Address:			
No. and Street Name (No PO Box Please)		City	State
			Zip

Home or Cell Phone: _____	Work Phone: _____
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**PRIMARY INSURANCE INFORMATION: Please check your insurance; fill in your insurance ID# and policyholder's name.**

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

**PLEASE ANSWER THE FOLLOWING QUESTIONS**

1. Have you had a life-threatening/severe allergic reaction to gelatin, antibiotics, eggs, latex, or to any component of any of the flu vaccine? <i>If yes, circle which one.</i> See package inserts for more information.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever had a serious reaction to any of the influenza (flu) vaccines in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever been diagnosed with Guillain-Barré Syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are you intensely sick or with a fever of >100 degrees today?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

1. Do you have long-term health problems with heart, lung, kidney, neuromuscular/neurologic, liver, or metabolic (e.g. diabetes) diseases; or anemia or other blood disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem; or in the past 3 months, have you taken medication that weakened your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs; or have you had radiation treatments?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you in close contact with a severely immunosuppressed person who requires protective isolation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are you pregnant or is there a chance you might become pregnant within the next month?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you taken an antiviral medication such as Tamiflu® (Oseltamivir), Relenza® (Zanamivir), Symmetrel® (Amantadine), Flumadine® (Rimantadine) within the last 48 hours?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you been immunized with a live vaccine MMR (Measles/Mumps/Rubella), MMRV (Measles/Mumps/Rubella/Varicella), Chicken Pox (Varicella), Shingles (Zostavax), Yellow Fever or FluMist within the past 4 weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No

I have received and read the Influenza Vaccine Information Statement dated 08/19/2014. 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			
Place vaccine label here or complete: 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: ____/____/____