Pomperaug District Department of Health
Seasonal Influenza Vaccine Administration Record (2018-19)
For Persons 6 months and Older

Please Print Clearly

Last Name	First Name	M.I.

Street Address	Town	State	Zip Code

Phone #	Date of Birth	Age	Gender ☐ Male ☐ Female	If under 10 years old, weight:

Email Address

Method of Payment: *We accept: Medicare Part B, ConnectiCare, Aetna, Cigna, Anthem BC/BS, and HUSKY for* ***children*** *through 18 years.* NOT accepted: Access Health CT / CT Exchange plans (gold, silver bronze) UnitedHealthcare & others not listed above.

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

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

Non-Medicare Plans:
- ☐ **ConnectiCare (non-Medicare)**
- ☐ **Anthem BC/BS (non-Medicare)**
- ☐ **Aetna (non-Medicare)**
- ☐ **Cigna (non-Medicare)**
- ☐ **HUSKY / Medicaid**

Insurance ID # *(Primary Insurance)*

Subscriber Name

Check Vaccine Preference:
- ☐ **Quadrivalent** (ages 6 mo. & up) (regular flu shot)
- ☐ **FluMist** (nasal spray; healthy persons age 2-49 yrs.)
- ☐ **High Dose** (optional for age 65 & older)
- ☐ **Flublok** (adult 18 yrs. & older with egg allergy)

Fill out this section and sign on the day of the clinic

Please Answer The Following Four Questions

- ☐ Yes ☐ No Is person sick or does person have a fever?
- ☐ Yes ☐ No Any allergies to eggs / thimerosal / components of vaccine?
- ☐ Yes ☐ No Ever had Guillain-Barré Syndrome?
- ☐ Yes ☐ No Ever had a serious reaction to a flu shot?

For PDDH Use Only
☐ **VFC**
Attach Eligibility Form

If receiving FluMist, please answer additional questions for the person receiving the vaccine:

- ☐ Yes ☐ No Received any vaccine in the past 4 weeks?
- ☐ Yes ☐ No Under 5 yrs. old with an episode of wheezing in the past year?
- ☐ Yes ☐ No Any allergies to gelatin / gentamicin / arginine?
- ☐ Yes ☐ No Living with a person who has a severely compromised immune system?
- ☐ Yes ☐ No Pregnant or nursing?
- ☐ Yes ☐ No Receiving influenza antiviral medication in past 48 hours (all ages) OR long-term aspirin therapy (age 18 yrs. & under)
- ☐ Yes ☐ No Have long-term health condition (i.e. asthma, heart disease, diabetes, seizures, cerebral palsy), a weakened immune system due to AIDS/HIV, or other conditions that affect the immune system?

I have read or had explained to me the Vaccine Information Statement (VIS 8/7/2015) 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
Dose: ☐0.5ml IM **Site:** ☐LD ☐RD ☐LT ☐RT ☐0.2ml intranasal
For child 6m – 8yr: 2nd dose required in 28 days ☐No ☐Yes & Parent informed
Administered by: __________ Date: __________

Vaccine Manufacturer & Lot #: