

# Visiting Nurse & Hospice of Litchfield County



## INFLUENZA VACCINE CONSENT FORM - 2024

Name \_\_\_\_\_ Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex (M/F) \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_

Phone Number \_\_\_\_\_ Zip Code \_\_\_\_\_

**The flu vaccine will be billed to:** \_\_\_\_\_ **Primary Policyholder's Name:** \_\_\_\_\_

Aetna # \_\_\_\_\_ Anthem Blue Cross # \_\_\_\_\_

Harvard Pilgrim HC # \_\_\_\_\_ Medicare Part B # \_\_\_\_\_

ConnectiCare # \_\_\_\_\_ United Health Care Advantage (over age 65) # \_\_\_\_\_

☐ CASH ☐ CHECK \_\_\_\_\_ Regular \$50.00 \_\_\_\_\_ High Dose \$95.00 Other \_\_\_\_\_

Are you allergic to eggs? ☐ No ☐ Yes

Have you ever had a serious reaction to a flu shot? ☐ No ☐ Yes

Have you ever had Guillain Barre Syndrome? ☐ No ☐ Yes

Are you sick with a fever? ☐ No ☐ Yes

### Required by State of CT – CT Wiz (Connecticut Immunization Information System):

Hispanic or Latino? ☐ Yes ☐ No ☐ Decline to Specify

Race: ☐ White ☐ Black/African American ☐ Asian  
☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander ☐ Other Race

Consent to Share Immunization with CT Wiz: ☐ Yes ☐ No

### **Influenza Consent**

I have read, or had explained to me, the information sheet about *influenza* vaccination. I have had a chance to ask questions which were answered to my satisfaction and I understand the benefits and risks of the vaccination as described. I request that the **flu** vaccination be given to me (*or the person named above for whom I am authorized to make this request*). I have had an opportunity to review this agency's materials on privacy. I authorize the release of any medical or other information necessary to process a Medicare/Insurance claim or for other public health purposes. **I understand that if my insurance carrier does not cover this shot, I will be responsible for full payment.**

Signature of recipient(*or parent/guardian*) \_\_\_\_\_

\_\_\_\_\_  
Date

**INFLUENZA Vaccination Site:** \_\_\_\_ *Left arm* \_\_\_\_ *Right arm*

#### Regular Fluzone:

Manufacturer: Sanofi Pasteur Inc.

Lot #: \_\_\_\_\_

Exp. Date: \_\_\_\_\_

Nurse Signature \_\_\_\_\_

#### High Dose Flud (over age 65):

Manufacturer: Seqirus Inc.

Lot #: \_\_\_\_\_

Exp. Date: \_\_\_\_\_

**Vaccine Information Sheet (VIS) 8/6/2021**