Visiting Nurse & Hospice of Litchfield County

INFLUENZA VACCINE CONSENT FORM - 2026

Name_____ Birth Date____/____/____Today's Date_____

Address_____ City/State_____

Phone Number_____ Zip Code_____Sex (M/F)____

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 $100.00** **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 necesssary 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 Inc

Lot #: _____

Exp. Date: _____

High Dose Fluad (over age 65):

Manufacturer: Seqirus Inc.

Lot #: _____

Exp. Date: _____

Nurse Signature_____

Vaccine Information Sheet (VIS) 1/31/2025