



Naugatuck Valley Health District
Influenza Vaccine Consent Form
(2020-21)

Please **Print** Clearly

Last Name		First Name			M.I.	
Street Address				Town	State	Zip Code
Phone #	Date of Birth (Month/Day/Year)	Age	Gender (circle one) Male Female	Email		

Please Answer The Following Questions:

Yes No

Yes No 1. Are you sick today?

Yes No 2. Have you ever had a serious reaction to the flu shot?

Yes No 3. Any allergies to eggs, thimerosal, or other components of the vaccine?

Yes No 4. Have you ever had Guillain-Barre syndrome?

Method of Payment: Insurance that is accepted: Aetna, Anthem BC/BS, Cigna, Connecticare and Medicare Part B. All others must pay by cash, check, or credit card. **Insurance that is not accepted: UnitedHealthcare, Access Health CT and others not listed above.**

Circle one: Aetna Anthem Cigna Connecticare Medicare Private Pay

Insurance ID #: _____ Are you the primary cardholder: Yes No

I have read, or had explained to me, the information sheet about influenza vaccinations and the Naugatuck Valley Health District's privacy policy. 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 influenza vaccination be given to me (or the person named above whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process all insurance claims. ****I understand that if my insurance does not cover the influenza vaccine that I will be financially responsible for payment and will be invoiced by NVHD.**

Signature: _____
Signature of Recipient (Parent/Guardian if under 18)

Date: _____

For Clinic Use Only

Vaccine Information:

Injection Site: Deltoid _____ Left _____ Right VIS Date: 8/15/19

Administered by: _____ Date VIS/Vaccine Given: _____

For NVHD Staff Use Only

Staff Initials: _____

_____ Insurance

_____ Private Pay: _____ Cash _____ CC

_____ No Charge