Naugatuck Valley Health District

Influenza Vaccine Consent Form (2023-24)

Please Print Clearly

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

Please Answer The Following Questions:

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?

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 by 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: ____ **Date:** __________________

Signature of Recipient (Parent/Guardian if under 18)

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 Medicaid Medicare Private Pay CVP Program

Insurance ID #: _______________________________ **Primary Cardholder:** ______________________________

<u>For Clinic Use Only</u>

Vaccine Information:

Injection Site: Deltoid _____ Left _____ Right VIS Date: 8/6/21

Administered by: _________________ Date VIS/Vaccine Given: ____________