Public Health
Prevent. Promote. Protect.
Naugatuck Valley Health District

Naugatuck Valley Health District

Influenza Vaccine Consent Form (2025-26)

Please <u>Print</u> Clearly

Last Name	First Name	M.I.

Street Address	Town	State	Zip Code

Phone #	Date of Birth (Month/Day/Year)	Age	Gender	Email

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?

Please Answer the Following Questions:

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)

<u>For Clinic Use Only</u>

Vaccine Information:

Injection Site: Deltoid _____ Left _____ Right VIS Date: 1/31/25

Administered by: _____ Date VIS/Vaccine Given: _____