



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

Naugatuck Valley Health District
Influenza Vaccine Consent Form (2025-26)

Please Print 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 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: _____ **Date:** _____
Signature of Recipient (Parent/Guardian if under 18)

Method of Payment: Insurance that is accepted: Aetna, Anthem BC/BS, Cigna, ConnectiCare, Medicaid, Medicare Part B, and United Healthcare. All others must pay by cash, check, or credit card.

Circle one: Aetna Anthem Cigna ConnectiCare Husky Medicare UHC Private Pay CVP Program

Insurance ID #: _____ **Primary Cardholder:** _____

For Clinic Use Only

Vaccine Information:

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

Administered by: _____ Date VIS/Vaccine Given: _____