MERIDEN HEALTH AND HUMAN SERVICES DEPARTMENT

ADULT

INFLUENZA IMMUNIZATION CONSENT FORM

Last Name ______ First ______ Initial ______ Date of Birth ______ Sex ______

Address ______ City ______ State ______ Zip ______

Home phone number ______ Cell phone number ______

Medicare number ______ Medicare HMO number ______ Husky number ______

Cigna number ______ Aetna number ______

☐ Yes ☐ No Are you allergic to eggs or egg products?

☐ Yes ☐ No Are you allergic to thimerosal, neomycin, polymyxin, or latex?

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

☐ Yes ☐ No Are you sick with a fever?

☐ Yes ☐ No Have you had Guillan-Barre Syndrome?

☐ Yes ☐ No Do you have an active neurological disorder?

I have read, or had explained to me, the information sheet about the influenza vaccine (flu shot). I have had a chance to ask questions which were answered tomy satisfaction. I understand the benefits and risks of the vaccine as described. I request the influenza vaccine be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare/insurance form.

X ______ Date ______
Signature of Recipient (or Parent/Guardian)

X ______ Date ______
Signature of person completing form for recipient

DO NOT WRITE BELOW THIS LINE - FOR CLINIC USE ONLY

☐ Fluzone HD Lot#: UJ73 Mfr. SP Site: ______ Date on VIS: 8/21 Vaccinator/date: ______

☐ Flulaval Lot#: E9R4 Mfr. GS Site: ______ Date on VIS: 8/21 Vaccinator/date: ______

Updated: 9/20/2021