MERIDEN HEALTH AND HUMAN SERVICES DEPARTMENT

INFLUENZA IMMUNIZATION CONSENT FORM ★CHILD★

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 _____ _____

Signature of Recipient (or Parent/Guardian) Date

X _____ _____

Signature of person completing form for recipient Date

DO NOT WRITE BELOW THIS LINE -FOR CLINIC USE ONLY

☐ Fluzone Quadr Lot#: UT7317J Mfr. SP Site: _____ Date on VIS: 8/21 Vaccinator/date: _____

☐ Flumist Quad Lot#: WH2013 Mfr. Med Site: _____ Date on VIS: 8/21 Vaccinator/date: _____