



Town of Darien

Health Department

INFLUENZA IMMUNIZATION CONSENT FORM

Name: _____

Date of Birth: _____

Street Address: _____

Phone: _____

Male Female

MEDICARE (Part B) Number	ConnectiCare Number	Self Pay
		<input type="checkbox"/> Check <input type="checkbox"/> Cash

Do you have allergies to eggs or other substances?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Have you ever had a serious reaction to a flu shot?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Have you ever had a neurological disease or Guillian-Barre Syndrome?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are you sick with a fever?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are you pregnant?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is this your first flu shot?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are you the age of 9 or under?	<input type="checkbox"/> No <input type="checkbox"/> Yes

I have read, or had explained to me, the information sheet about **influenza (flu)** vaccine. 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 **flu** vaccination 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 or insurance claim or for other public health purposes. **In the event that my insurance does not cover the cost of my vaccine, I agree to make payment.**

Signature of recipient (or parent/guardian)

Date

Injection Site: <input type="checkbox"/> Left Arm <input type="checkbox"/> Right Arm	VIS 08/15/19 _____	Provider initial _____
Manufacture & Lot Number: _____	MD/Nurse Signature: _____	Date _____