



INFLUENZA VACCINATION (FLU SHOT) CONSENT FORM

Last Name _____ First Name _____

Address _____ City _____ State _____ Zip _____

Email Address: _____

Date of Birth _____ Age _____ Sex: M _____ F _____ Phone _____

Medicare Recipients Only:

MEDICARE# (with letter after it) _____

HEALTHNET Managed Medicare ID # _____

Private Insurance:

- AETNA
CONNECTICARE
ANTHEM/EMPIRE BC/BS
CIGNA (for Town of Ridgefield and Board of Ed. employees only)

Member ID#
Name of Insured
Relationship to Insured

If not covered by any of the above, payment method:

- Cash
Check
Visa

*Please Answer Health Questions Below on the Day of the Clinic

- *Are you allergic to eggs, gelatin, or Thimerosal?
*Are you sick today?
*Have you ever had Guillain-Barré Syndrome?
*Have you ever had a serious reaction to the influenza vaccine?
* If child receiving flu shot is 6 months through 8 years of age, has your child EVER had a flu shot or flu mist before?

I have read the CDC Vaccine Information Statement (dated 8/11/09) about either the inactivated influenza vaccine or live, intranasal influenza vaccine. I have had a chance to ask questions to my satisfaction. I understand the benefits and risks of the influenza vaccine and request that the vaccine be given to me or to the person named above for whom I am authorized to make the request. I agree to stay in the general area for fifteen (15) minutes after receiving my vaccination. I authorize the release of any medical information or other information necessary to process an insurance claim. I understand that RVNA will submit my claim to Medicare Part B, HealthNet Managed Medicare, Cigna (for Ridgefield Town and Board of Ed. employees only) Anthem/Empire BC/BS, Aetna, or ConnectiCare, when applicable. I understand I am responsible for any copay or deductible and if for any reason my claim is denied I understand that I will be billed for the entire amount of the service. The Ridgefield VNA has made their "Notice of Privacy Practices" available to me.

Please, sign and date the day of the clinic ONLY

*SIGNATURE _____ DATE: _____
(parent or guardian must sign for patients under 18 years of age)

Nurse's Use ONLY:

GSK/Fluarix 0.5mL GSK/FluLaval (vial) 0.5mL Sanofi/Fluzone 0.5mL Sanofi PEDI Fluzone (6-35 months ONLY) 0.25ml
L R Deltoid / L R Thigh Lot# Exp: 6/10

Parent informed of need for 2nd dose in 28 days, if applicable

Given By: _____ Date _____