Public Health
Prevent. Promote. Protect.
Trumbull Health Department

Trumbull Health Department

335 White Plains Road
Trumbull, CT 06611

Influenza Vaccine Consent Form

Patient's Name: Date of Birth: Age:

Phone: Email Address:

Address: Town: State: Zip:

Insurance Policy Holder: Insurance Policy Holder DOB:

Please answer the following:

Is this your first flu shot EVER?	◯ Yes	◯ No
Have you ever had a SERIOUS reaction to a flu shot?	◯ Yes	◯ No
Are you sick today?	◯ Yes	◯ No
Do you have an allergy to an ingredient of this vaccine?	◯ Yes	◯ No
Have you ever had Guillian-Barre Syndrome?	◯ Yes	◯ No
Have you ever felt dizzy or faint before, during or after a shot?	◯ Yes	◯ No
Are you anxious about getting a shot today?	◯ Yes	◯ No
Do you have any questions for your nurse?	◯ Yes	◯ No

Consent

I request that the influenza vaccination be given to me (or the person(s) named above for whom I am authorized to make this request).

- **HIPAA & VIS:** I have read or had explained to me, the Vaccine Information Statement (VIS) about influenza vaccination and the Trumbull Health Department's privacy. 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 understand that ALL vaccines administered at the Trumbull Health Department are recorded in the state vaccine database, CtWiz.
- **Right to Refuse:** I understand that the Trumbull Health Department has the right to refuse to vaccinate anyone if the THD, its agents, or employees deem that in their discretion the minor or anyone with them is uncooperative and by attempting to vaccinate could lead to a safety issue for the vaccinator, the minor or others in the vicinity.
- **Billing Consent:** I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim. I understand that if my insurance rejects payment for this vaccination the Trumbull Health Department will bill me and will agree to pay the fee.

X_____ _____

Signature of Recipient (or parent/guardian) **Date**

Scan here for a copy of the VIS.
Physical copies of information sheets, or those in different languages, are available upon request at the front desk.

For Office Use Only:

Place Sticker here: Right:

Left:

_____ _____

Nurse Signature **Date**