Public Health
Prevent. Promote. Protect.
TRUMBULL HEALTH DEPARTMENT

Trumbull Health Department
335 White Plains Road, Trumbull, CT 06611
Phone (203) 452-1030 • Fax (203) 452-1050

INFLUENZA VACCINE CONSENT FORM

Patient's name: _____ Date of Birth _____ / _____ / _____ Age:_____

Address: _____ Town: _____ Zip_____ Phone: _____

Parent name if under 18: _____ Pediatrician: _____ Town: _____

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

How did you hear about this clinic?	
Social Media	☐
Signs (LED Sign on Road, Pink Flag, Yard Signs)	☐
Town News Page/Town Email Blast	☐
Word of Mouth	☐
Other_____	☐

CONSENT

I request that the influenza vaccination be given to me (or the person 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.

PLEASE PRESENT A PHOTO ID AND ALL INSURANCE CARDS TO BE PHOTOCOPIED. THANK YOU!

X_____ _____

Signature of Recipient (or parent or 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.

Place sticker here:	Right
	Left

_____ _____

Nurse Signature Date