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
Are you allergic to eggs, Thimerosal, any vaccine ingredient or latex?	Yes / No
Have you ever had a neurological disease or Guillian-Barre Syndrome?	Yes / No
Are you pregnant or a nursing mother?	Yes / No

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 policy (If completing this online, this information is available for download). 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____ **Date:** ____________________________
Signature of recipient (or parent or guardian)

DO NOT WRITE BELOW.

Place sticker here:	Right Left

____ _________________________
Nurse Signature **Date**

8/3/22sc