

EAST SHORE DISTRICT HEALTH DEPARTMENT 2022-2023 Influenza Clinic

688 East Main St Branford, CT (203)481-4233

Private Pay rate: Quadrivalent Vaccine \$40.00 High Dose Vaccine \$70.00 Egg Free \$70.00 Clinic location:

Print clearly exactly as it appears on the card

Name (print) _____ Date of Birth ____/____/____ ☐ M ☐ F

Address _____ City/State _____ Zip _____

Telephone: _____ e-mail _____

Insurance Co.	Check here if Medicare plan	ID#	Prim Ins.	Secondary Ins.
Medicare Part B				
Anthem BC/BS				
ConnectiCare				
CIGNA				
Aetna				
Husky				
United Healthcare				
Harvard Pilgrim				

Who is the insurance under (write name as it appears on the card):

Subscriber's name: _____ (First) (Middle Initial) (Last) Subscriber's Date of Birth: ____/____/____

PLEASE COMPLETE AND SIGN

1. Is this **your first flu** vaccination ever? ☐ Yes ☐ No
2. Have you ever had a serious reaction to a flu shot? ☐ Yes ☐ No
3. Are you allergic to eggs or thimerosal? ☐ Yes ☐ No
4. Did you ever become ill with Guillain-Barre Syndrome after a flu vaccine? ☐ Yes ☐ No
5. Are you sick with a fever today? ☐ Yes ☐ No
6. Have you received any other vaccines in the past 30 days? ☐ Yes ☐ No

If requesting Nasal Vaccine (only available for ages 2 thru 49):

7. Do you have asthma, or live with someone immunocompromised, are you pregnant? ☐ Yes ☐ No

I have read or had explained to me, the information sheet about influenza vaccination. 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 and I authorize the release of any medical or other information necessary to process an insurance claim or for other public health reasons. I understand that ESDHD may bill me for any co-payment or deductible and that it is my responsibility to accurately provide correct insurance information.

Signature of Vaccine Recipient / or parent/legal guardian/healthcare agent

Date

Below Is For Health Department Use Only

ADULT <input type="checkbox"/> Fluzone <input type="checkbox"/> Fluarix Egg Free <input type="checkbox"/> Flucelvax <input type="checkbox"/> Flublok <input type="checkbox"/> Nasal Adult 18-49 years	65 and older <input type="checkbox"/> Fluzone HD Senior Strength <input type="checkbox"/> Flud Senior Strength	CHILDREN (2-17 YEARS) <input type="checkbox"/> Nasal 2-17 years <input type="checkbox"/> FLUCELVAX
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Flu Vaccine administered: ☒ IM ☐ Left arm ☐ Right arm ☐ Nasal

Nurse Signature: _____ Date: ____/____/____