EAST SHORE DISTRICT HEALTH DEPARTMENT

2014 Influenza Clinic

Please check town where employed:

☐ **Branford** ☐ **North Branford** ☐ **East Haven**

Please indicate town department: _____

Name (Please print) _____ **Date of Birth**____/____/____ M___F___

Address_____ City/State_____ Zip_____

Telephone _____ Physician_____

Insurance Co.	ID #	Group #	Prim Ins.	Second Ins.
Anthem BC/BS				
Medicare Part B				
ConnectiCare				
CIGNA				
Aetna				
Other				

Subscriber's name: _____**Subscriber's Date of Birth ____/____/____**

PLEASE COMPLETE AND SIGN

Is this your first flu vaccination ever? . . . . . ☐ Yes ☐ No

Have you ever had a serious reaction to a flu shot? . . . . . ☐ Yes ☐ No

Are you allergic to eggs or other components of the vaccine?. . . . ☐ Yes ☐ No

Did you ever become ill with Guillain-Barre Syndrome after a flu vaccine? . . ☐ Yes ☐ N0

Are you sick with a fever today? . . . . . ☐ Yes ☐ No

FLU MIST ® Nasal Spray: Must be 2-49 years old: Do you have *Asthma*, are you *pregnant*, are you in contact with someone who is severely *immunocompromised*, do you take *aspirin* daily. ☐ 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.
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 that is my responsibility.

X _____

Vaccine Recipient's Signature/ or parent/guardian **Date**

For Health Department use:

Manufacturer and Lot number:

Sanofi # _____ exp. 6/30/15 ☐

VFC _____ **#_____** exp.__/___/__ ☐

Novartis # _____ exp.__/____/__ Fluvirin® ☐

GSK #_____ exp.__/____/___ ☐

MedImmune Flu Mist® Nasal Spray #CF2251 exp. 11/24/1 ☐

_____ # _____ exp. _/____/___ ☐

Flu Vaccine administered: IM ☐ Left arm ☐ Right arm OR Flu Mist ® Nasal spray ☐

Nurse Signature_____ **Date**____/_____/_____