HOUSATONIC VALLEY HEALTH DISTRICT
SEASONAL INFLUENZA VACCINE ADMINISTRATION RECORD (2022-2023)

Please review, correct and fill in missing info below:

Name _____ **Date** _____

Address _____ **County:** _____ **Phone #** _____

Date of Birth _____ **Age** _____ **Gender:** _____

If under 10 yrs. old, weight: _____

For persons under 19 years, name of Parent(s) or Legal Guardian(s) _____

Email: _____ **Need Proof of Vaccination?** ☐Yes ☐No

Method of Payment: See reverse side for accepted insurance. **MUST present insurance cards for person listed above - ID numbers may be different for each individual.** We reserve the right to refuse service if card is not presented.

☐ **Medicare Insurance** ☐ **Non-Medicare Insurance** ☐ **Cash · Check · Credit Card**

Check Name of Insurance Plan:

- ☐ Medicare (Part B)
- ☐ ConnectiCare
- ☐ Anthem BC/BS
- ☐ Cigna
- ☐ Aetna
- ☐ UnitedHealthCare
- ☐ Oxford - UnitedHealthCare
- ☐ HUSKY / Medicaid

Other: _____

Insurance ID # (Primary Insurance) _____

Subscriber Name _____

Please answer the following five questions for the person receiving vaccination:

☐Yes ☐No **Is person receiving the flu vaccine between 6 months - 8 years of age?**
If YES, Did the child receive at least 2 doses of any influenza vaccine before July 1, 2022? (Doses need not have been received during the same or consecutive seasons.) ☐ **Yes** ☐ **No** ☐ **Unknown**
If NO or UNKNOWN, child needs 2 doses for 2022-23, at least 4 weeks apart.

☐Yes ☐No **Is person sick or have fever on the day the person is receiving the flu vaccine?**

☐Yes ☐No **Any allergies to eggs or thimerosal?**

☐Yes ☐No **Ever had Guillain-Barré Syndrome?**

☐Yes ☐No **Ever had an allergic reaction after a flu vaccine or have any other severe life threatening allergies?**

For Clinic Use:
☐ **CVP**
Attach Eligibility Form

If receiving FluMist, please answer additional questions for the person receiving vaccination:

☐Yes ☐No **Received any vaccine in the past 4 weeks?**

☐Yes ☐No **Child 2 - 4 years old old with asthma or an episode of wheezing in the past 12 months?**

☐Yes ☐No **Close contact with a person with a severely compromised immune system who requires a protected environment?**

☐Yes ☐No **Pregnant or nursing?**

☐Yes ☐No **Receiving influenza antiviral medication in past 48 hours (all ages) OR receiving aspirin (age 2 - 17 yrs.)?**

☐Yes ☐No **Have any of these medical conditons: asthma, lung/heart disease, kidney/liver disorder, neurologic/neuromuscular disorder, diabetes/metabolic disorder?**

☐Yes ☐No **Have a weakened immune system due to certain medications or health conditions: HIV, cancer, medications such as steroids or those used to treat cancer, psoriasis, Chrohn's disease, RA, etc.?**

You will receive the Vaccine Information Statement at the clinic

I have read or had explained to me the Vaccine Information Statement about seasonal influenza and the influenza vaccine. I have had a chance to ask questions and I understand the benefits and risks of the influenza vaccine. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I authorize the release of any medical or other information necessary to process an insurance claim. I have read and agree to the Pomperaug Health District's privacy policy. I understand that if my insurance does not fully cover the fee for this vaccination that the Pomperaug Health District may bill me for the balance of the fee.

Signature _____ **Date** _____

For Clinic Use:

Dose: ☐ 0.5ml IM ☐ 0.7ml IM **Site:** ☐ LD ☐ RD ☐ LT ☐ RT ☐ 0.2 ml intranasal

Vaccine Manufacturer & Lot #

Administered by: _____ **Date:** _____

Bring this form with you to clinic with Medicare / Insurance Card

Insurance cards for <u>each person</u> must be presented at clinic

Save Time* Attach a copy of your cards to this form

We reserve the right to refuse service if insurance card is not presented.

Accepted Insurance:

Medicare (Part B) • Aetna • Cigna • UnitedHealthcare • HUSKY/Medicaid
Anthem BC/BS* • ConnectiCare*

(*with the exception of their HealthyAccessCT / CT Exchange Plans - platinum, gold, silver, bronze plans)

Appointments Required • Face Masks Required

Housatonic Valley Health District
77 Main Street North, Suite 205
Southbury, CT 06488

_____ _____

_____, ___

Flu Clinic Information and Vaccination Consent Form

Housatonic Valley Health District Flu Clinic Schedule

School Clinics are by appointment
Visit www.hvhd.us for schedule and link to make appointments

Clinics at Housatonic Valley Health District
Playhouse Corner, 77 Main Street North, Suite 205, Southbury
<u>Every Tuesday</u>, September 20 - October 11, 3:30 PM - 5:30 PM ** No clinic on Oct. 4*

2 Pickett District Road New Milford
<u>Every Wednesday,</u> September 21-October 12, 3:30 PM-5:30 PM

Appointments required. Call 203-264-9616, or visit www.hvhd.us