Housatonic Valley Health District
Seasonal Influenza Vaccine Administration Record (2023-2024)

Patient's name: _____ Date: _____

Date of Birth ____/____/____ Age: _____ Gender: _____

Race:

- ☐ American Indian
- ☐ Black/African American
- ☐ Asian
- ☐ White/Caucasian
- ☐ Hawaiian/Pacific Islander
- ☐ Other: _____
- ☐ Unknown

Ethnicity:

- ☐ Latino or Hispanic
- ☐ Not Latino or Hispanic
- ☐ Unknown
- ☐ Prefer not to say

Address: _____ Town: _____ Zip: _____

Phone: _____ Email: _____

For person under 19 years, name of Parent or Legal Guardian: _____

Insurance Information - MUST bring a **copy** of the insurance cards for person listed above (ID numbers may be different for each individual)

☐ Medicare ☐ Non-Medicare

Check name of insurance plan:

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

Insurance ID # _____

Subscriber Name: _____

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

☐ Yes	☐ No	Is the 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, 2023 (Does not need to have received during the same or consecutive seasons) Yes No Unknown If NO or UNKNOWN, the child needs 2 doses for 2023-24, at least 4 weeks apart.
☐ Yes	☐ No	Is the person sick or have a fever on the day the person is receiving the flu vaccine?
☐ Yes	☐ No	Any allergies to eggs or thimerosal
☐ Yes	☐ No	Ever had Guillain-Barre Syndrome
☐ Yes	☐ No	Ever had an allergic reaction after a flu vaccine or have any other severe life threatening allergies?

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 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 Housatonic Valley Health District's privacy policy. I understand that if my insurance does not fully cover the fee for this vaccination that Housatonic Valley 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

Vaccine Manufacturer & Lot #: _____

Administered by: _____ Date: _____