For Official Use Only: ☐ **M** ☐**MA** ☐ **I** ☐ **P** **Checker's Initials:** ____

GREENWICH DEPARTMENT OF HEALTH
Influenza Immunization Consent Form

Today's Date:__________

PLEASE PRINT

Full Name ____________________ Telephone #______________

Address ____________________

City __________ State ____ Zip Code ______ ☐ **Self Pay: $35.00 – Seasonal**

Sex Male ☐ Female ☐ Date of Birth ______ * **~~Self Pay: $55.00 – High Dose~~**

Medicare and Private Insurance Information – fill out 1, 2 or 3: (*I agree that if for any reason my insurance claim is denied, I will still be held responsible for payment in full to the Town of Greenwich for services rendered*.)

1. **Traditional Medicare (Part B):** ID #______________________________

2. **Medicare Advantage Plan (Aetna not Accepted):** ______________________ID #______________

   Billing Address: ____

3. **United Health/Oxford Plan** ☐ **Anthem** ☐

   Member ID #______________________________Group #______________________

If Applicable:

Primary Insured's Name: Last ____________________ First ______________Date of Birth__________

Primary Insured's Address ________________________City____________State_____Zip______

Primary Insured's Telephone____________________ Relationship to Primary Insured______________

Have you ever received a flu shot?	**NO**☐	**YES**☐	**Year** __________
1. Have you ever had a serious reaction to a flu shot?	**NO**☐	**YES**☐	
2. Have you ever had Guillain Barre Syndrome?	**NO**☐	**YES**☐	
3. Are you allergic to eggs or other components of the Influenza vaccine?	**NO**☐	**YES**☐	
4. Are you sick with a fever today?	**NO**☐	**YES**☐	

*If **Yes** to any of the questions 1-4 above, call your medical provider prior to attending the flu clinic*

Influenza vaccination consent:

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 risk of the vaccination as described. I request that the influenza vaccination 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 a Medicare/Private Insurance claim or for other public health purposes. I acknowledge that a copy of the Greenwich Department of Health HIPAA Privacy notice is available for my review or available should I request it.

Your personal information shall be held strictly confidential

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Signature of recipient (or parent or guardian)

Fluarix Quadrivalent 0.5ML GlaxoSmithKline

Administered by: ____________________

~~**FLUZONE HIGH DOSE 0.5ML** Sanofi Pasteur~~

***HIGH DOSE VACCINE-**
NOT AVAILABLE FROM DISTRIBUTOR

Injection Site: LEFT ARM

Inactivated Influenza Vaccine - 08/15/19 **VIS given** ☒

September 2020