INFLUENZA VACCINATION CONSENT FORM 2017

The 2017-2018 Quadrivalent influenza vaccines provide protection against and contain: A/Michigan/45/2015 (H1N1) pdm09-like virus; an A/Hong Kong /4801/2014 (H3N2)-like virus; an B/Brisbane/60/2008-like virus (B/Victoria lineage); and a B/Phuket/3073/2013-like virus (B/Yamagata lineage).

I have read the adverse reactions and precautions about influenza vaccine described in the Vaccine Information Statement. I have been provided the opportunity to ask questions about the vaccination. I understand that I/my child may experience some or all of the adverse reactions from the vaccination as described in the Vaccine Information Statement (Inactivated) 8/7/2015 - 42 U.S.C. § 300aa-26. I understand the benefits and risks of influenza vaccination and request that the vaccine be given to me or the person below for whom I am authorized to sign.

Name:_____ **Date of Birth:** _____ **Age:**_____
Please Print Clearly

Address: _____

□Plainville or □Southington Municipal Employee Dept. you work for:_____

□ Medicare □ Medicare Advantage HMO □ Commercial Insurance:Name:_____

□ No insurance. A $20 fee is required upon registration. A receipt will be provided.
No one will be refused vaccination for inability to pay.

Insurance ID Number:_____ **Group Number:**_____

Subscriber:□ Self □ Other: Name_____ **Date of Birth**_____

Signature:_____ **Date signed**_____
□ Self □ Parent / Guardian

Please answer the following questions

1. Is patient allergic to eggs? □ Yes □ No *2. Previous allergic reaction to flu vaccine?* □ Yes □ No

3. Has patient ever had Guillain-Barre (severe muscle weakness after agetting a flu vaccine)? □ Yes □ No

4. Is patient moderate/severely ill? □ Yes □ No

---------- (For Office Use Only – Do not write below this line) ----------

Manufacturer and Name	Age	CPT	NDC
FLUZONE Intradermal Quadrivalent (Sanofi-Pasteur)			
0.5 mL prefilled syringes [preservative (*thimerosal)* & latex free]	≥ 3 years	□**90686** □**Q2038**	49281-0417-50

ADMINISTRATION CODES:	ICD-10/DIAGNOSIS:	IM INJECTION SITE:
□ **90471** ≥ 19 yo provider counseling or any age nurse counseling	□ **Z23** Enc for imm.	**Deltoid:** □ Right / □ Left
□ **G0008** for Medicare/Medicare Advantage, any age		□ Second Dose

Lot Number: UT5937KA Expiration Date: 30 June 2018

Administered by: _____ **□ MD □ APRN □ RN □ LPN**

Signature: _____ **Date:**_____

PLAINVILLE-SOUTHINGTON REGIONAL HEALTH DISTRICT