Town of New Canaan Health Department ***Clinic Date*****_____**

2010 INFLUENZA IMMUNIZATION CONSENT FORM

Payment: **Cash____ Check____ Debit____ MasterCard____ Visa____**

Medicare____ Town Employee____ Volunteer____ NCVAC____

_____ _____

Name (please print) Date of Birth

_____ _____ _____

Address State Zip Code

Phone #_____ Gender: Male Female

Medicare Part B #_____

Yes___ No___ Are you allergic to eggs or egg products?

Yes___ No___ Are you allergic to thimerosal, neomycin, polymyxin or latex?

Yes___ No___ Have you ever had a serious reaction to a flu shot?

Yes___ No___ Are you sick with a fever?

Yes___ No___ Have you ever had Guillain-Barre Syndrome?

Yes___ No___ Do you have an active neurological disorder?

I have read, or had explained to me, the information sheet about the influenza vaccine (flu shot) and the agency's policy. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine as described. I request that the influenza 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 a Medicare claim.

X_____ _____

Signature of recipient (or parent/guardian) Date

(_____)

(Signature of person completing form for recipient unable to read the form)

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DO NOT WRITE BELOW THIS LINE **FOR CLINIC USE**

Manufacture: _____ Lot # _____ Expiration Date: _____

Injection site: Left Arm _____ Right Arm_____

Nurse's Signature _____ Date_____