

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 a getting 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 (<i>thimerosal</i>) & latex free]	≥ 3 years	<input type="checkbox"/> 90686 <input type="checkbox"/> Q2038	49281-0417-50

ADMINISTRATION CODES:	ICD-10/DIAGNOSIS:	IM INJECTION SITE:
<input type="checkbox"/> 90471 ≥ 19 yo provider counseling or any age nurse counseling	<input type="checkbox"/> Z23 Enc for imm.	Deltoid: <input type="checkbox"/> Right / <input type="checkbox"/> Left
<input type="checkbox"/> G0008 for Medicare/Medicare Advantage, any age		<input type="checkbox"/> Second Dose

Lot Number: UT5937KA Expiration Date: 30 June 2018

Administered by: _____ MD APRN RN LPN

Signature: _____ Date: _____

PLAINVILLE-SOUTHINGTON REGIONAL HEALTH DISTRICT