Visiting Nurse Association of Central CT, Inc.
205 West Main Street, New Britain, CT 06052
860-224-7131

Influenza / Pneumococcal Immunization Consent Form

Clinic Location: ______________________________ Clinic Date: ______________

Name:______________________________ Birth Date:______________

Address:______________________________ City/State/Zip:______________

Phone: (   )______________________________ M___ F___

Payment Information

Insurance

Medicare # ______________________

Blue Cross ID # ______________________

Connecticare ID #______________________

Aetna ID # ______________________

HealthNet #______________________

Cash/Check

Cash Flu ❒ Pneumococcal ❒

Check Flu ❒ Pneumococcal ❒

Are you allergic to eggs or Thimerosal?	❒ No	❒ Yes
Have you ever had a serious reaction to a flu shot?	❒ No	❒ Yes
Have you ever had Guillain Barre Syndrome?	❒ No	❒ Yes
Are you sick with a fever?	❒ No	❒ Yes
Are you pregnant?	❒ No	❒ Yes

INFLUENZA consent:

A copy of the information sheet about influenza vaccination and the agency's privacy policy was made available to me to read or where requested, explained to me. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccination as described. I request that the flu vaccination be given to me (*or 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/Insurance claim or for other public health purposes. I understand that I will remain financially responsible to Visiting Nurse Association of Central CT Inc for charges for services furnished by them to the extent not covered or paid by the insurance company.

______________________ ____________
Signature (recipient or guardian) Date

PNEUMONIA consent - **65 years or older**:

A copy of the information sheet about pneumonia vaccination and the agency's privacy policy was made available to me to read or where requested, explained to me. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccination as described. I request that the pneumonia vaccination be given to me (*or 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/Insurance claim or for other public health purposes. I understand that I will remain financially responsible to Visiting Nurse Association of Central CT Inc for charges for services furnished by them to the extent not covered or paid by the insurance company.

______________________ ____________
Signature (recipient or guardian) Date

DO NOT WRITE BELOW THIS LINE - OFFICE USE ONLY

Dosage**: INFLUENZA 0.5 ml IM**
Injection Site: ❒ Left Arm ❒ Right Arm
Manufacturer**: Sanofi Pasteur** Lot #:__________**EXP:**________
Chiron Lot #:__________ **EXP:**________

______________________ ___/___/___
Nurse Signature Date

Dosage**: PNEUMOVAX 0.5 ml IM**
Injection Site: ❒ Left Arm ❒ Right Arm
Manufacturer**: Merck** Lot #:__________**EXP:** ________

______________________ ___/___/___
Nurse Signature Date