WINDSOR HEALTH DEPARTMENT
INFLUENZA VACCINATION RECORD 2018

☐ **FLU SHOT- REGULAR**
Quadrivalent

ACCEPTED INSURANCE

- ☐ Medicare Part B
- ☐ Anthem BC & BS
- ☐ ConnectiCare
- ☐ Cigna
- ☐ United HealthCare
- ☐ Other _____

Please Print

Name Last | First | Middle Initial

Address Street

City | State | Zip

Phone#

Sex | Date of Birth

MEDICARE ID NUMBER

INSURANCE ID NUMBER (other than Medicare)

FOR CIGNA INSURANCE ONLY
Doctor's Name & Address

Doctor's Name | Address | City | State | Zip

Are you allergic to any of the following?
Eggs Yes____ No____ Latex Yes____ No____ Thimerisol Yes____ No____.

YES NO Have you ever had a serious reaction to a flu shot?

YES NO Are you taking any blood thinners?
(i.e. Asprin, coumadin, plavix, etc.)

YES NO Are you sick with a fever **TODAY**?

YES NO Have you ever had Guillain-Barre Syndrome?
(caused by a virus and can cause paralysis)

YES NO Are you currently receiving radiation, chemo, or other immunosuppressive therapy?

YES NO Are you pregnant or nursing?

I have read or have had explained to me the information sheet on influenza vaccine (flu shot). I have had a chance to ask questions that were answered to my satisfaction and I understand the benefits and risks of the vaccination as described. I approve the administration of the vaccine to me or to the person named below for whom I am authorized to give approval. I authorize the release of any medical information necessary to process a medical claim.

Signature_____ **Date**_____

For Clinic Use

Provider Name: Windsor Health Dept.
Clinic Location:
O Town Hall O **LP Wilson**
O_____ O Safety Complex

Injection [deltoid]
Right O
Left O

O PRE-FILL - 0.5ml: Lot # YZ7TR MFR: GSK-Fluarix GSK EXP: 6/30/2019
O PRE-FILL - 0.5ml: Lot # 499DE MFR: GSK-Fluarix GSK EXP: 6/30/2019
O PRE-FILL - 0.5ml: Lot # 4ZY53 MFR: GSK-Fluarix FFF EXP: 6/30/2019
O PRE-FILL - 0.5ml: Lot # MJ432 MFR: GSK-Fluarix GSK EXP: 6/30/2019

RN Signature: _____ **Date:** _____