Windsor Health Department
Seasonal Influenza Vaccine Administration Record (2021-2022)
For Persons 18 years old and older

Please Print Clearly

Last Name	First Name	M.I.

Street Address	Town	State	Zip Code

Phone #	Date of Birth	Age	Gender ☐ Male ☐ Female

Email Address

Method of Payment: *We accept: Aetna, Anthem BC/BS (with the exception of their Access Health CT/CT Exchange Plans – gold, silver, bronze), Cigna, ConnectiCare, Medicare Part B, and UnitedHealthcare.*

☐ **Insurance (Fill out insurance info below) OR** ☐ **$30.00 Cash**

Medicare Plans:
- ☐ **Medicare (Part B)**
- ☐ **Medicare Aetna**
- ☐ **Medicare Anthem BC/BS**
- ☐ **Medicare Cigna**
- ☐ **Medicare ConnectiCare**
- ☐ **Medicare UnitedHealthcare**

Non-Medicare Plans:
- ☐ **Aetna (non-Medicare)**
- ☐ **Anthem BC/BS (non-Medicare)**
- ☐ **Cigna (non-Medicare)**
- ☐ **ConnectiCare (non-Medicare)**
- ☐ **UnitedHealthcare (non-Medicare)**

Member ID Number:

Please answer the following five questions for the person receiving vaccine:

☐ Yes ☐ No Are you sick or do you have a fever today?
☐ Yes ☐ No Is this your first flu vaccine?
☐ Yes ☐ No Do you have any allergies to eggs / or thimerosal?
☐ Yes ☐ No Have you ever had Guillain-Barre Syndrome (GBS)?
☐ Yes ☐ No Have you ever had an allergic reaction to a flu vaccine, other vaccines or have any other severe allergies?

I have read or had explained to me the Vaccine Information Statement (VIS 8/6/2021) about seasonal influenza and the influenza vaccine. I have had a chance to ask questions and I understand the benefits and risks of the influenza vaccine. I request that the 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 an insurance claim. I have read and agree to the Windsor Health Department's privacy policy. ***I understand that if my insurance does not fully cover the fee for this vaccination or if a co-pay or deductible applies, I may be billed for the balance of the fee.***

_____ _____

Signature of Recipient (or guardian) **Date**

For Clinic Use ___ South Windsor ___ Windsor

Provider –Windsor Health Department

Clinic Location:
- ☐ Town Department
- ☐ School
- ☐ Other:_____

Injection Site:
- ☐ LD
- ☐ RD

Quadrivalent Influenza Vaccine – IM Dose:
- ☐ MFR: GSK-Fluarix-GSK Lot #54C23 EXP: 6/30/22
- ☐ MFR: GSK- Fluarix-GSK Lot #4L97X EXP: 6/30/22
- ☐ MFR: GSK- Flulaval-FFF Lot #AD49D EXP: 6/30/22

Administered by: _____ Date: _____