WINDSOR HEALTH DEPARTMENT
INFLUENZA VACCINATION RECORD 2019

☐ **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 # K3593 MFR: GSK-Fluarix GSK EXP: 6/30/2020
O PRE-FILL - 0.5ml: Lot # 54T44 MFR: GSK-Flulaval FFF EXP: 6/30/2020
O PRE-FILL - 0.5ml: Lot # ZZ772 MFR: GSK-Fluarix GSK EXP: 6/30/2020
O PRE-FILL - 0.5ml: Lot # _____ MFR: _____ EXP:

RN Signature: _____ **Date:** _____