CHATHAM HEALTH DISTRICT

2024-2025 Influenza Vaccination Consent

PLEASE PRINT CLEARLY

Last Name	First Name		
Street Address	Town		Zip Code
Phone #	Date of Birth	Age	Sex
Email Address	Physician		

Method of Payment: Insurances that are accepted: Medicare Part B, ConnectiCare, Aetna, Cigna, Anthem BC/BS. **WE DON'T ACCEPT ANY FORM OF UNITED HEALTHCARE.** Other forms of payment accepted are cash or check.

☐ Insurance (Fill out insurance info below) ☐ Cash or Check

Medicare Plans:
- □ Medicare Part B
- □ Medicare ConnectiCare
- □ Medicare Anthem BC/BS
- □ Medicare Aetna
- □ Medicare Cigna

Non-Medicare Plans:
- □ ConnectiCare (non-Medicare)
- □ Anthem BC/BS (non-Medicare)
- □ Aetna (non-Medicare)
- □ Cigna (non-Medicare)
- □ Husky A, B,C,D

Insurance ID# (primary insurance):

PLEASE MAKE A COPY OF BOTH FRONT AND BACK OF INSURANCE CARD AND ATTACH.

All questions pertain to the person to be vaccinated today:	**YES**	**NO**
1. Do you have an allergy to eggs or any component of the flu vaccine?		
2. Have you ever had a serious reaction to the flu vaccine?		
3. Are you sick or have a fever?		
4. Have you had any other vaccinations in the past four weeks?		
5. Ever been diagnosed with the paralyzing neuromuscular disease Guillain-Barre Syndrome?		
6. Are you pregnant? ***Intranasal Mist is not recommended for pregnant women.***		
7. Do you have a history of asthma, diabetes or any other auto-immune disease?		

☐ **I have received a copy of the Influenza Vaccine Information Statement (VIS 8/6/2021)**

Patient or Parent Signature: _____ **Date:** _____

If Under 18 Please Print Parent/Caregiver Name:

To Be Completed by Administering Nurse:

Manufacturer, Lot Number & Expiration Date:

Injection given: ☐ .25 ml IM Pediatric ☐ 0.5 ml IM ☐ Highdose IM ☐Nasal Mist

Site Administered: ☐RD ☐LD ☐RT ☐LT

_____ _____

Nurse Signature Date

Rev 7/15/24