



City of Stamford Department of Health

Safeguarding the Public's Health

PRINT & BRING THIS COMPLETED FORM WITH YOU TO THE CLINIC

888 Washington Blvd.
Stamford, CT 06901
(203) 977-4398

**2020 Seasonal Influenza
Immunization Consent Form**

Influenza Vaccination Consent Form

NAME: (Please print)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (month/day/year): ___ / ___ / ___
Street Address: <input type="checkbox"/> Home <input type="checkbox"/> Work		City, State, Zip code	
Email Address:		Phone #: <input type="checkbox"/> Home <input type="checkbox"/> Cell	
Please bring your insurance card or a copy with you to the clinic.			
INSURANCE (primary) – please circle the plan to be billed		INSURANCE ID # (primary)	
Medicare Part B		Relationship to Insurance Plan Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	
Name of Plan Holder:		Plan Holder Date of Birth: ___ / ___ / ___	

<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a severe allergy to eggs?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had Guillain-Barre Syndrome (weakness or paralysis) after a flu shot?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had any other severe reaction to a flu shot?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you sick with a fever today?

Privacy Notice: All information is kept confidential. Basic data (without your name) may be used by us to learn about community practices. We may choose to contact you in the future with information about influenza, other health concerns and/or other vaccinations.

Consent: By signing this form, you: (1) have asked to be vaccinated against influenza; (2) confirm that you have had a chance to ask questions and understand the benefits and risks of vaccination; (3) have received the vaccination information sheet and authorize the release of any information helpful to process an insurance claim. If the person being vaccinated is not able to sign for self or is a child and not of legal age, please indicate basis of legal authority / relationship.

Signature: _____ Relationship: _____

Date: _____

For Clinic Use:	<input type="checkbox"/> Please check if 1 st time ever getting a flu vaccine
	Type of Vaccine: <input type="checkbox"/> Fluzone <input type="checkbox"/> High Dose <input type="checkbox"/> Flublok <input type="checkbox"/> Other: _____
	Injection Site: <input type="checkbox"/> Right Arm <input type="checkbox"/> Left Arm <input type="checkbox"/> Other: _____
	Vaccinator's Signature: _____ Manufacturer & Lot Number (sticker): _____
	Date: _____