

**WINDSOR HEALTH DEPARTMENT
INFLUENZA VACCINATION RECORD 2011**

Cash

Flu Shot \$25.00

For Office Use

Medicare Part B

Other Insurance

Please Print

Accepted Insurance

NAME
Last First Middle

STREET ADDRESS

City State Zip

- Medicare Part B
- Anthem Blue Cross & Blue Shield
- ConnectiCare
- EverCare
- WellCare

MEDICARE NUMBER

INSURANCE CARD / HMO NUMBER

DATE OF BIRTH SEX Male Female

PHONE # Volunteer's Initials

STOP! Please ***DO NOT*** answer the following questions or sign this form until ***THE DAY OF THE CLINIC!***

- Yes No Are you allergic to: eggs latex thimerosal
- Yes No Have you ever had a serious reaction to a flu shot?
- Yes No Are you sick with a fever today?
- Yes No Do you take blood thinners (coumadin, Aspirin, etc.)?

- Yes No Have you ever had Guillain-Barre Syndrome? (Caused by a virus - it 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 had explained to me the information sheet about the **influenza vaccine (flu shot)**. I have had a chance to ask questions which were answered to my satisfaction and I understand the benefits and risks of the vaccination as described. I request that the influenza 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 information or other information necessary to process an Insurance, Medicare or Medicare HMO claim.

Signature _____ **Date** _____

For Clinic Use

Provider Name: Windsor Health Department
Clinic Location:
 LP Wilson Windsor Town Hall
 Safety Complex Other _____
Admin. Date 10-6-2011 **Other Date** _____

VIAL: Lot# _____ MFR: Novartis Exp Date: ___/___/2012
 PRE-FILLED: Lot# 110405 MFR: Novartis Exp Date: 04/30/2012
 PF/VIAL: Lot# _____ MFR: _____ Exp Date: ___/___/2012
Site of Injection: [deltoid] Left _____ Right _____ **Dosage:** 0.5ml
Signature / Initials of Vaccine Administrator: _____ / _____