ALLERGY ASSOCIATES OF HARTFORD, PC

INFLUENZA VACCINE CONSENT FORM AND ADMINSTRATION RECORD

Age Group	Dosage Schedule
19 years and older	0.5ML: One Dose
18 & younger	must receive at PCP's

INFORMATION ABOUT PERSON TO RECEIVE VACCINE (PLEASE PRINT AND FILL OUT COMPLETELY)

Name:_____ Birth date:_____
Last First MI

Address:_____
Street Name & Number City State Zip

Phone number: _____ Insurance:_____

I have read or have had explained to me the Vaccine Information Statement about influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risk of influenza vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request for (parent or guardian). I authorize billing to my insurance company and understand any services not covered by my insurance are my responsibility.

X_____ Date:_____
Patient Signature

1. Have you received flu vaccine before? ___No ____Yes
2. Did you have any problems with previous flu shots? ___No ____Yes
3. Are you ill today? ___No ____Yes
4. Do you have allergies to eggs or to Thimerosal Mercury (a medication preservative)?
   Please answer no to an egg allergy if you can eat foods with egg in them ___No ____Yes
5. Do you have a history of Guillian-Barre Syndrome (a paralysis problem)? ___No ____Yes

_____FOR OFFICE USE ONLY_____

Copy of insurance on file? ____No ____Yes

Date Vaccine administered: _____

Vaccine Manufacturer & Lot Number Fluzone Lot number: U1684AD U16784AA EXP 6/17

Site of IM injection RDT or LDT or _____ Dose 0.5 ML 0.25ML

Signature of nurse administering vaccine:_____ Date:_____

Billing

All insurance except Medicare 90471 90688 Diagnosis Z23

Medicare G0008 Q2038 Diagnosis Z23