

# Pomperaug District Department of Health Influenza Vaccine Administration Record (2008) For Person 9 years and Older

Please Print

Name \_\_\_\_\_  
Last First M.I.

Address \_\_\_\_\_  
Street Town State Zip Code

Day Phone: \_\_\_\_\_ Last 4 Digits of Social Security # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex:  Male  Female

**Please Check Method Of Payment:**

- Cash  Check  Medicare ID# \_\_\_\_\_
- HealthNet (Medicare) ID# \_\_\_\_\_
- HealthNet (Non Medicare) ID# \_\_\_\_\_
- Connecticare (Medicare) ID# \_\_\_\_\_
- Connecticare (Non Medicare) ID# \_\_\_\_\_
- Anthem Blue Cross & Blue Shield \_\_\_\_\_

For Clinic Use Initials _____ _____ VFC	Plan Type _____ <small>i.e. Blue Care, Century Preferred, State Preferred, Century 90, HSA, FEHP, etc.</small>
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**Please Answer The Following Questions:**

- Yes  No Are you sick with a fever?
- Yes  No Have you ever had a serious reaction to a flu shot?
- Yes  No Are you allergic to eggs, gelatin, or thimerosal (a preservative)?
- Yes  No Have you ever had Guillain-Barré Syndrome?

*I have read or had explained to me the information sheet (VIS 7/24/2008) about influenza and the influenza vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine and request that the 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 or other information necessary to process a Medicare or insurance claim. I have read and agree to the Pomperaug District Department of Health's privacy policy. I understand that if my insurance does not fully cover the fee for this vaccination that the Pomperaug District Department of Health will bill me. I agree to pay the balance of the fee.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

<b>For Clinic Use</b>	Provider Name: Pomperaug District Department of Health DX Code: V04.81 Admin. Code: G0008 CPT Code: 90658 Site of Injection: <input type="checkbox"/> Left Deltoid <input type="checkbox"/> Right Deltoid	Vaccine Manufacturer & Lot #: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>
Date Administered: _____	Signature & Title of Vaccine Administrator: _____	