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| **8 Old Mill Lane Simsbury, CT 06070****860-651-3539** | **2023 Influenza Vaccination Consent Form***Please print all information clearly.* |
| First Name | Last Name |
| Street Address | City/State/Zip |
| Telephone Number | Sex |
| Date of Birth | Age |
| Insurance Co.  | Insurance ID Number (**not group number**) |

|  |  |  |
| --- | --- | --- |
| Are you sick with a fever? Temp taken: | Yes  | No |
| Are you allergic to eggs? | Yes  | No |
| Have you ever had a serious reaction to a flu shot? | Yes | No |
| Have you ever had Guillain-Barre syndrome? | Yes | No |

Privacy Practices (HIPAA, 8.15) and Vaccine Information Sheet (VIS, 8.21): I have received or reviewed these documents and understand the benefits and risks of the flu vaccine. (please initial) HIPAA \_\_\_\_\_\_\_ VIS \_\_\_\_\_\_
Consent to treat: I hereby give my consent for treatment for myself or the person named above. Release of Information: I authorize Farmington Valley VNA, Inc. to release any and all information necessary to process an insurance claim to the payer indicated above or for any other health purposes. Assignment of Benefits: I authorize my insurance company to pay the Farmington Valley VNA for my influenza vaccine.

**By signing below, I agree that I have read, and understand, the above information.**

Patient (parent/guardian) Signature: Date:

**For Internal Use Only** C:Documents/Jean/Flu/2023/ConsentForm

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| --- | --- | --- | --- |
| Bill Company | Town /BoE Employee | Town Funds | FV VNA Staff |
|  |  |  |  |
| Vaccination Site: | Left Arm\_\_\_\_\_ | Right Arm\_\_\_\_\_ |  Regular Dose\_\_\_\_\_\_\_ | High Dose\_\_\_\_\_\_\_\_\_ |

Manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lot#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RN Signature: Date: STICKER HERE!