



Name: \_\_\_\_\_  Male  Female Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_

Address: \_\_\_\_\_  
(No PO Box please) City State Zip

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Clinic Location: \_\_\_\_\_

**Insurance Information.** Please mark the child's insurance, fill in the insurance ID # and the policy holder.

Anthem/Blue Cross  Aetna  Cigna  ConnectiCare  Oxford  
 HUSKY/No ins.

Insurance ID # \_\_\_\_\_ Name of Policy Holder: \_\_\_\_\_

**Form of Payment** IF YOU DO NOT HAVE ANY OF THESE INSURANCE COMPANIES PLEASE MARK YOUR FORM OF PAYMENT BELOW. DO NOT MARK A PAYMENT IF YOU FILLED IN AN INSURANCE THAT WE ACCEPT.

Cash  Check # \_\_\_\_\_  Master Card  VISA

*I agree that if my insurance company does not pay for the vaccine or if a co-payment or deductible applies, I will receive a bill from DVNA and that I am responsible for payment.*

**Please answer the following:**

Is your child sick today?  Yes  No  
Does your child have an allergy to eggs or thimerosal?  Yes  No  
Has your child ever had a reaction to any vaccine?  Yes  No  
Has your child ever been diagnosed with Guillain-Barré Syndrome?  Yes  No

**Please answer the following ONLY IF the child is 6 months through 8 years of age:**


Did your child receive a seasonal flu vaccine in the last year?  Yes  No

**Please answer the following ONLY IF you want the child to receive the Flu Mist vaccine:**

Is your child younger than 2 years of age?  Yes  No  
Is your child receiving aspirin therapy or aspirin- containing therapy?  Yes  No  
Is your child pregnant?  Yes  No  
Does anyone living with child have a severely compromised immune system?  Yes  No  
Has the child received MMR or varicella vaccine in the past 4 weeks?  Yes  No  
Does your child have asthma, active wheezing or recurrent wheezing (2-5 yrs old)?  Yes  No  
Did your child have one or more episodes of asthma within the past year?  Yes  No  
Does your child have a weakened immune system?  Yes  No  
Does your child have long-term health problems?  Yes  No

I have received the Intranasal /Inactivated Influenza Vaccine Information Statement dated 7/26/11. I have had a chance to ask questions and I understand the benefits and risks of the vaccine. I request that the vaccination be given to me (or to the person for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process the insurance claim or for other public health purpose. I have received a copy of Notice of Privacy Practices.

Signature of Parent/Guardian: \_\_\_\_\_ Print name: \_\_\_\_\_

**(Staff Use Only)**  
 Flu Mist (2 yrs & older)  Not eligible / Declined  6-35 mos  Sanofi (T-Free .25)  
3 yrs & older  Sanofi (Multi .50)  Sanofi (T-Free .50)  GSK (T-Free .50)  
Lot # \_\_\_\_\_ Exp: \_\_\_\_\_ Site:  RArm  LArm  RThigh  Lthigh  Intranasal  
Given by: \_\_\_\_\_ Date: \_\_\_\_\_