WESTERN CONNECTICUT HOME CARE

DANBURY HOSPITAL • NEW MILFORD HOSPITAL

FLU PREVENTION PROGRAM

STAFF USE
☐ CT State Clinic
Clinic Site: _____
Verified by: _____

2012 PEDIATRIC INFLUENZA IMMUNIZATION CONSENT

PLEASE COMPLETE FORM IN LEGIBLE PRINT

Patient Name (As it appears on insurance card)	Gender ☐ M ☐ F	D.O.B.: ___/___/___	Age:
Address:			
No. and Street Name (No PO Box Please)	City	State	Zip
Home or Cell Phone:	Work Phone:		

PRIMARY INSURANCE INFORMATION: Please check your insurance; fill in your insurance ID# and policyholder's name.

- ☐ Aetna
- ☐ Anthem/Blue Cross / ☐ *CT State Employee Plan*
- ☐ Blue Cross *(other than Anthem)*
- ☐ Cigna
- ☐ ConnectiCare
- ☐ Medicaid (Husky B/SCHIP) (under 18 years old)
- ☐ MultiPlan Network
- ☐ Oxford / ☐ *CT State Employee Plan*

Insurance ID#: _____

Policy Holder (not company) if other than patient:

_____

Direct Payment:

☐ Other insurance not listed or No Insurance

Paid by: ☐ Cash ☐ Check #_____ ☐ MC ☐ VISA

Amount Paid: _____

I understand I will receive a bill from WCHC for any portion of this claim my insurance company does not pay and I agree to pay the bill in full within 30 days of receipt.

PLEASE ANSWER THE FOLLOWING QUESTIONS

Is your child sick with a fever 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
IF YOUR CHILD IS 6 MONTHS THROUGH 8 YEARS OF AGE PLEASE ANSWER THE FOLLOWING:	☐ Not Applicable
Has this child ever received a flu vaccine?	☐ Yes ☐ No
Did this child receive a seasonal flu vaccine in both 2010 and 2011, or two doses in either year?	☐ Yes ☐ No
FLUMIST: PLEASE ANSWER ONLY IF THIS CHILD IS GOING TO RECEIVE THE FLUMIST	☐ Not Applicable
Is this child younger than 2 years of age?	☐ Yes ☐ No
Is this child receiving aspirin therapy or aspirin- containing therapy?	☐ Yes ☐ No
Is this child pregnant or is there a chance she is pregnant ?	☐ Yes ☐ No
Does anyone living with this child have a severely compromised immune system or has had a transplant?	☐ Yes ☐ No
Has this child received MMR or varicella vaccine in the past 4 weeks?	☐ Yes ☐ No
In the last 12 months, has a healthcare provider told you that this child had wheezing or asthma? (under 5 yrs. old only)	☐ Yes ☐ No
Does this child have a weakened immune system?	☐ Yes ☐ No
Does this child have long-term health problems such as diabetes, heart, lung, kidney or liver disease?	☐ Yes ☐ No
Does this child suffer from a muscle or nerve disorder such as seizure disorders or cerebral palsy?	☐ Yes ☐ No

I have read the Influenza Vaccine Information Statement dated 07/02/2012. 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 read the Notice of Privacy Practices. I agree to pay all unpaid charges billed to me by Western Connecticut Home Care.

Signature: _____ Print Name: _____

STAFF USE ONLY

Place vaccine label here or complete:

☐ Vial ☐ FluMist ☐ T-Free Vaccine Brand:_____ Lot #: _____ Exp. Date:_____

Site: ☐L Arm ☐R Arm ☐Intranasal ☐L Thigh ☐R Thigh | Administered by: _____ | Date: _____ /_____ / 2012