# EAST SHORE DISTRICT HEALTH DEPARTMENT 2023-2024 Influenza Clinic

**688 East Main St Branford, CT (203)481-4233**

**Private Pay rate:** Quadrivalent Vaccine $40.00 High Dose Vaccine $80.00 Egg Free $80.00 Clinic location**:**

**Print clearly exactly as it appears on the card**

Name (print) _____ Date of Birth____/____/____ ☐M ☐F

Address_____ City/State_____ Zip_____

Telephone: _____ e-mail_____

| Insurance Co. | Check here if Medicare plan | ID# | Prim Ins. | Secondary Ins. |
|---|---|---|---|---|
| **Medicare Part B** | | | | |
| **Anthem BC/BS** | | | | |
| **ConnectiCare** | | | | |
| **CIGNA** | | | | |
| **Aetna** | | | | |
| **Husky** | | | | |
| **United Healthcare** | | | | |
| **Harvard Pilgrim** | | | | |

*Who is the insurance under (**write name as it appears on the card**):*

***Subscriber's name:*** _____ **Subscriber's Date of Birth**: ___/___/___

(First) (Middle Initial) (Last)

**PLEASE COMPLETE AND SIGN**

1. Is this **your first flu** vaccination ever? ☐ Yes ☐ No
2. Have you ever had a serious reaction to a flu shot? ☐ Yes ☐ No
3. Are you allergic to eggs or thimerosal? ☐ Yes ☐ No
4. Did you ever become ill with Guillain-Barre Syndrome after a flu vaccine? ☐ Yes ☐ No
5. Are you sick with a fever today? ☐ Yes ☐ No
6. Have you received any other vaccines in the past 30 days? ☐ Yes ☐ No

**If requesting Nasal Vaccine** (only available for ages 2 thru 49):

7. Do you have asthma, or live with someone immunocompromised, are you pregnant? ☐ Yes ☐ No

I have read or had explained to me, the information sheet about influenza vaccination. I have had a chance to ask questions which were answered to my satisfaction and I understand the benefits and risks of the vaccination as described. I request that the flu vaccination be given to me and I authorize the release of any medical or other information necessary to process an insurance claim or for other public health reasons. I understand that ESDHD may bill me for any co-payment or deductible and that it is my responsibility to accurately provide correct insurance information.

***Signature of Vaccine Recipient / or parent/legal guardian/healthcare agent*** **Date**

**Below Is For Health Department Use Only**

| ADULT | 65 and older | CHILDREN (2-17 YEARS) |
|---|---|---|
| ☐ Fluzone<br>☐ Fluarix<br>☐ Afluria<br>☐ Flulaval<br><br>Egg Free<br>☐ Flucelvax<br>☐ Flublok<br><br>☐ Nasal Adult 18-49 years | ☐ Fluzone HD Senior Strength<br>☐ Fluad Senior Strength | ☐ Nasal 2-17 years<br>☐ FLUCELVAX |

**Flu Vaccine administered: IM ☐ Left arm ☐ Right arm ☐ Nasal**

**Nurse Signature**: _____ **Date_____/_____/_____**