EAST SHORE DISTRICT HEALTH DEPARTMENT 2024-2025 Influenza Clinic

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

Private Pay: Traditional Flu Vaccine $40.00 High Dose Vaccine $85.00 Flu Blok:$ 85.00 Egg Free $85.00 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				

*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? (If you had a flu shot before select NO) ☐ Yes ☐ No
2. Have you ever had a serious reaction to a flu shot? ☐ Yes ☐ No
3. Are you allergic to eggs or preservatives/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 yes, name of other vaccine you received in past 30 days:_____

Only 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 ☐ Fluarix ☐ Afluria ☐ Flulaval Egg Free ☐ Flucelvax ☐ Flublok ☐ Nasal Adult 18-49 years	☐ Fluzone HD Senior Strength ☐ Fluad Senior Strength	☐ Nasal 2-17 years ☐ FLUCELVAX

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

Nurse Signature: _____ **Date**_____/_____/_____