Visiting Nurse & Hospice of Fairfield County
a member of Waveny LifeCare Network

2023-2024 INFLUENZA VACCINE CONSENT FORM FOR 48 MONTHS TO 18 YEARS

Please print

NAME *Last* ____________ *First* ____________ *MI* ______

ADDRESS ____________ CITY, STATE ____________ ZIP ______

HOME PHONE ____________ DOB ____________ AGE ______

PEDIATRICIAN ____________ ADDRESS ____________

COST: $55 ☐ Cash ☐ Check#______ or Billed to Anthem/BCBS

Insurance ID # ____________ Name of Policy Holder ____________

Relationship to Patient ____________ Policy Holder Date of Birth ____________

*** I understand that if my insurance carrier does NOT pay for the vaccine and administration, or if a co-pay applies, I am still responsible for payment to Visiting Nurse & Hospice of Fairfield County.***

Please complete the following section upon arrival at the clinic:

☐ *Yes* ☐ *No* *Is your child sick with a fever today?*

☐ *Yes* ☐ *No* *Is your child allergic to eggs or to preservative thimerosal?*

☐ *Yes* ☐ *No* *Has your child ever had a reaction to any vaccine?*

☐ *Yes* ☐ *No* *Has your child ever had Guillain-Barre Syndrome?*

☐ *Yes* ☐ *No* *Has your child previously received seasonal flu vaccine?*

CONSENT TO HAVE INFLUENZA VACCINE ADMINISTERED TO CHILD UNDER AGE 18
I understand it is my responsibility to have discussed this vaccine with my pediatrician and to notify him/her that my child has received it. I have read, or had explained to me, the 2023-2024 Influenza Vaccine Information Statement and have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of influenza vaccine and ask that the vaccine be administered to the child named above for whom I am authorized to make this request. I authorize the release of any medical information or other information necessary to process an insurance claim and to notify my pediatrician of his/her receiving flu vaccine. I have read and agree to the agency's Notice of Privacy Practices.

PARENT/GUARDIAN SIGNATURE: ____________ **DATE:** ____________

STAFF USE ONLY

Provider Name: Visiting Nurse Hospice of Fairfield County, 22 Danbury Road, Wilton, CT 06897
DX Code: Z23 Admin. Code: G0008 CPT Code: 90674

Site of Injection: ☐ Deltoid ☐ Thigh ☐ L ☐ R 0.5 ml ☐ Vaccine Manufacturer: ____________

Vaccine Lot#: ____________ Expiration Date: ____________

RN Signature: ____________ Date: ____________