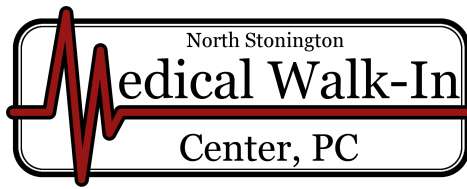


82 Norwich-Westerly Road
North Stonington CT 06359



Phone: (860)599-2469
Fax : (860)599-2830

Influenza Immunization Authorization

Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Social Security: _____ - _____ - _____

- Are you allergic to eggs? Yes _____ No _____

 - Have you ever had a serious reaction to the flu vaccine? Yes _____ No _____

 - Are you presently sick with fever? Yes _____ No _____

 - Are you presently pregnant? Yes _____ No _____

 - Have you ever had Guillain-Barre Syndrome? Yes _____ No _____
-

I have read, or had explained to me, the information sheet relating to the influenza vaccine (flu shot). I have been given the chance to ask questions and have been provided answers by this medical practice. I understand the benefits and risks of the vaccination as described in the information sheet provided.

I request the influenza vaccine 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 a medical insurance or Medicare claim.

Signature of Recipient (or Parent/Guardian)

Date

For Clinic Use: Injection Site: Left arm: _____ Right arm: _____

Manufacturer: _____

Lot No: _____ Expiration: _____

Medical Staff Initials: _____ Date: _____
