82 Norwich-Westerly Road
North Stonington CT 06359

North Stonington Medical Walk-In Center, PC

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:_____