



PHARMACY COPY

543 W. Main St. - New Britain, CT 06053 - (860) 225-6487
233 Main St. - New Britain, CT 06051 - (860) 356-3270

Influenza Vaccine Consent Form and Administration Record

Personal Information (PLEASE PRINT)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M F
Address: \_\_\_\_\_ City: \_\_\_\_\_
State: \_\_\_\_\_ Zipcode: \_\_\_\_\_ Phone Number: \_\_\_\_\_
Email: \_\_\_\_\_

Screening Checklist (ADULTS & CHILDREN)

Table with 3 columns: Question, Yes, No, Don't Know. Contains 5 screening questions regarding vaccination status and allergies.

I have read or have had explained to me the Vaccine Information Statement about influenza and the influenza vaccine. I have had the chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request (parent/guardian). [VIS Edition Date 8/6/21]

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

[if guardian, relationship to patient] \_\_\_\_\_

CHECK VACCINE TYPE:

Vaccine manufacturer Seqirus Fluad Quadrivalent (65 and older)
Lot #: 371597 Expiration: 5/22/24

Vaccine manufacturer Seqirus Flucelvax Quadrivalent
Lot #: 944467 Expiration: 6/26/24

Dose: 0.5 mL Route: IM

Date Administered: \_\_\_\_\_ Location: Left Deltoid / Right Deltoid

Immunizer: \_\_\_\_\_ Title: Intern / Pharmacist



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## Insurance Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Insurance Company: \_\_\_\_\_  
[used for insurance billing purposes only]

Cardholder Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Cardholder ID: \_\_\_\_\_ Rx BIN #: \_\_\_\_\_

PCN: \_\_\_\_\_ Rx Group #: \_\_\_\_\_

*\*If no insurance, cost to patient is:* **Flucelvax: \$51.00**  
**Fluad: \$72.99**



**PATIENT COPY**

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## Influenza Vaccine Consent Form and Administration Record

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I have read or have had explained to me the Vaccine Information Statement about influenza and the influenza vaccine. I have had the chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request (parent/guardian). *[VIS Edition Date 8/6/21]*

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

[if guardian, relationship to patient] \_\_\_\_\_

Vaccine Manufacturer: Seqirus Flucelvax Quadrivalent

Lot #: \_\_\_\_\_ Expiration: \_\_\_\_\_

Dose: 0.5 mL Route: IM

Date Administered: \_\_\_\_\_ Location: Left Deltoid / Right Deltoid

Immunizer: \_\_\_\_\_