Home & Community Health Services, Inc.

101 Phoenix Avenue
Enfield, CT 06082
Phone: 860-763-7600
Web: www.jmmc.com

jmmc
Johnson Memorial Medical Center
Health care. The way it should be.

Date _____/_____/_____
M D Y

2011 Influenza Immunization

Please Print

_____ ___ _____ Somers High School
First Name MI Last Name Clinic Site

_____ _____ _____
Street City/State Zip

☐ Male ☐ Female Date of Birth ____/____/____ (_____) _____
M D Y Phone number

Medicare

☐ Medicare – Part B

__ __ __ __ __ __ __ __ __ _____
Medicare Claim Number Letter

Managed Medicare-Advantage Plan

☐ Blue Cross and Blue Shield of _____
☐ ConnectiCare *Medicare VIP*
☐ WellCare

_____
Insurance Number

Private Insurance

☐ Aetna (Not "Better Health")
☐ Blue Cross and Blue Shield of _____
☐ ConnectiCare
☐ Fallon Community Health Plan
☐ Harvard Pilgrim Health Plan

_____
Insurance Number

_____
Employer

Private Pay

☐ Flu……..$35…cash

☐ Flu……..$35…check

Checks payable to HCHS or Home & Community Health Services, Inc.

Are you allergic to latex	☐ No	☐ Yes
Are you allergic to eggs or Thimerosal?	☐ No	☐ Yes
Have you ever had a serious reaction to a flu shot?	☐ No	☐ Yes
Have you ever had Guillain Barre Syndrome? (A neurological condition resulting in paralysis)	☐ No	☐ Yes
Are you sick with a fever?	☐ No	☐ Yes
Are you pregnant?	☐ No	☐ Yes
Are you currently receiving radiation, chemotherapy or immunosuppressive therapy or have you been treated for Hodgkin's disease?	☐ No	☐ Yes (If yes, doctor's note required.)

INFLUENZA CONSENT: I hereby give my permission for authorized personnel of your agency to perform all necessary procedures. A copy of the information sheet about influenza vaccine and the agency's privacy policy was made available to me to read or where requested, explained to me. 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 the flu vaccination be given to me (*or the person named above for whom I am authorized to make this request*). I authorize the release of any medical or other information necessary to process a Medicare of insurance claim or for other public health purposes.

If the flu vaccine is not covered by your insurance company you will be billed privately. You are responsible for any co-payments.

X_____
Signature of recipient (or parent or guardian)

INFLUENZA Injection Site: ☐ Left arm ☐ Right arm Manufacturer & Lot Number: _____

_____ ____/____/___
Nurse Signature Date

☐ **Please check box if you wish to have a copy of the consent form mailed to you at the above address.**