Public Flu Clinics 2022
East Shore District Health Department
688 EAST MAIN STREET – BRANFORD, CT 06405

Guilford Community Center
32 Church Street – Guilford
Friday 9/30/22
10:00 a.m. – 12:00 p.m.

East Shore District Health Department
688 East Main Street – Branford
Saturday 10/01/22
10:00 a.m. – 1:00 p.m.

Branford Community House
46 Church Street – Branford
Tuesday 10/4/2022
1:00 p.m. – 6:00 p.m.

Bethany Town Hall
40 Peck Road-Bethany
Wednesday 10/5/2022
10:00 a.m. – 12:00 p.m.

Stanley T. Williams Senior Center
1332 Middletown Avenue- Northford
Wednesday 10/12/2022
11:30 a.m. – 1:00 p.m.

Old Stone Church
251 Main Street- East Haven
Wednesday 10/19/2022
3:30 p.m. – 5:30 p.m.

East Shore District Health Department
Walk-In Clinics:
688 East Main Street - Branford
Every Wednesday 3:00-5:00 p.m.
From November 2, 2022, through December 28, 2022
**Exception:**
There will be no clinic on Wednesday November 23rd, the clinic that week will be held on Tuesday November 22nd

Fight the Flu
It starts with you

Participating Insurances
- 65 years or older
  - Medicare Part B
  - Aetna Medicare
  - Anthem BCBS Medicare
  - ConnectiCare VIP
  - United Healthcare Managed Medicare Plans

- All others:
  - Aetna
  - Anthem BCBS
  - CIGNA
  - ConnectiCare
  - Harvard Pilgrim
  - Husky
  - Medicaid
  - United Healthcare

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- Come with a completed flu form and a copy of your insurance card
- OUR FLU FORM CAN BE FOUND ON OUR WEBSITE www.esdhd.org
- All participants must wear a mask
- Come prepared: Wear short sleeve

Vaccine available: While supplies last
- Preservative free quadrivalent vaccine
- High Dose / Senior Strength vaccine
- Nasal vaccine for those 49 years or younger without asthma or not immunocompromised
- Egg free vaccine
EAST SHORE DISTRICT HEALTH DEPARTMENT  2022-2023 Influenza Clinic
688 East Main St Branford, CT (203)481-4233

Print clearly exactly as it appears on the card

Name (print) ___________________________ Date of Birth ___/___/____ □ M □ F
Address ___________________________ City/State _______________ Zip __________
Telephone: ___________________________ e-mail ______________________

<table>
<thead>
<tr>
<th>Insurance Co.</th>
<th>Check here if Medicare plan</th>
<th>ID#</th>
<th>Prim Ins.</th>
<th>Secondary Ins.</th>
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<tbody>
<tr>
<td>Medicare Part B</td>
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<td>Anthem BC/BS</td>
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<td>ConnectiCare</td>
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<td>United Healthcare</td>
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<tr>
<td>Harvard Pilgrim</td>
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Who is the insurance under {write name as it appears on the card}:
Subscriber's name: ___________________________ Subscriber's Date of Birth ___/___/____
[First] [Middle Initial] [Last]

PLEASE COMPLETE AND SIGN

1. Is this your first flu vaccination ever? ................................................................. □ Yes □ No
2. Have you ever had a serious reaction to a flu shot? ................................................ □ Yes □ No
3. Are you allergic to eggs or thimerosal? ..................................................................... □ Yes □ No
4. Did you ever become ill with Guillain-Barre Syndrome after a flu vaccine? ............. □ Yes □ No
5. Are you sick with a fever today? ................................................................................ □ Yes □ No
6. Have you received any other vaccines in the past 30 days? ...................................... □ Yes □ No

If requesting Nasal Vaccine (only available for ages 2 thru 49):
7. Do you have asthma, or live with someone immunocompromised, are you pregnant? □ Yes □ No

I have read or had explained to me, the information sheet about influenza vaccination. 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 that the flu vaccination be given to me and I authorize the release of any medical or other information necessary to process an insurance claim or for other public health reasons. I understand that ESDHD may bill me for any co-payment or deductible and that it is my responsibility to accurately provide correct insurance information.

Signature of Vaccine Recipient / or parent/legal guardian/healthcare agent ___________________________ Date ___________________________

Below Is For Health Department Use Only

<table>
<thead>
<tr>
<th>ADULT</th>
<th>65 and older</th>
<th>CHILDREN (2-17 YEARS)</th>
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<tbody>
<tr>
<td>□ Fluzone</td>
<td>□ Fluzone HD Senior Strength</td>
<td>□ Nasal 2-17 years</td>
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<tr>
<td>□ Fluarix</td>
<td>□ Fluzone HD Senior Strength</td>
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<tr>
<td>Egg Free</td>
<td>□ Fluarial</td>
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<td>□ Flucelvax</td>
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<td>□ Flublok</td>
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<td>□ Nasal Adult 18-49 years</td>
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Flu Vaccine administered: IM □ Left arm □ Right arm □ Nasal

Nurse Signature: ___________________________ Date ___/___/____