Seasonal Influenza Vaccine 2019 – 2020 Consent, Screening and Insurance Information Form

The completion of this form is necessary for every vaccine recipient. If no insurance information is available, please fill out as much as possible using existing information.

Information about the person to receive vaccine (please print): *Required Fields

Name: (Last, First, MI)*	Date of birth: * ____ ____ ____ Month Day Year	Age*	Sex: (Circle)* Male Female
Street Address:*			
City:*	State: *	Zip:*	Phone:*

Insurance Information: *Include the whole member ID number and any letters that are part of that number*

Name of Insurance Company:*	Member ID Number:*	Group ID #: (if available)
Medicare Member ID #:"	Is Medicare Primary? Yes No	Is Subscriber Retired? Yes No

If person getting vaccinated is not the subscriber, please complete the following:

Subscriber's Name: (Last, First, MI)*	Subscriber's Date of Birth: * ____ ____ ____ Month Day Year	Sex: (Circle)* Male Female
Subscriber's Street Address:* (If different from address above)		
City:*	State:*	Zip: *	Phone:*
Patient Relationship to Subscriber: (Circle)* Spouse Child Other		

For children 18 years of age and younger:

- ☐ Is enrolled in Medicaid (includes MassHealth and HMOs, etc., if enrolled through Medicaid)
- ☐ Does not have health insurance
- ☐ Is American Indian (Native American) or Alaska Native
- ☐ Has health insurance and is not American Indian (Native American) or Alaska Native

I have been given a copy and have read, or had explained to me the 2019-2020 Vaccine Information Statement (VIS) for the Seasonal Influenza vaccine and understand the risks and benefits. I have been given a copy and have read, or had explained to me the Massachusetts Immunization Information System (MIIS) Fact Sheet for Parents and Patients. I voluntarily give consent for the person named above to be vaccinated. I give permission to bill my/his/her health insurance.

X _____ Date: _____ **TURN FORM OVER QUESTIONS ON BACK**

(Signature of patient, parent or legal guardian)

For Clinic /Office Use Only:

Vax Type / Injection Route Manufacturer	Lot No. Expiration Date	Preservative Free State Supplied	Dose (Circle)	Dose No. (Circle)	Injection Site & Route (Circle)	Date on VIS
			0.5 ml	Dose #1 Dose #2	IM R Arm L Arm IM R Leg L Leg	8/15/19

Provider Name & Address: Hamilton Board of Health, 577 Bay Road, Hamilton, MA 01982 MDPH Provider PIN #: 10612

Signature of Vaccine Administrator: _____ Date of Service/Date VIS Given: _____

A. The following questions are necessary to determine if the person to be vaccinated should get the 2019-2020 seasonal influenza vaccine today. Please mark YES or NO for each question.	**YES**	**NO**
1. Does the person to be vaccinated have an allergy to eggs?		
2. Does the person to be vaccinated have an allergy to gentamicin, neomycin, polymixin or gelatin?		
3. Is the person to be vaccinated sick today?		
4. Has the person to be vaccinated ever had a serious reaction to a previous dose of vaccine?		
5. Has the person to be vaccinated had Guillain-Barre Syndrome within 6 weeks of receiving a flu vaccine?		

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Place Photo Copy of Card Here: