2018 – 2019 INFLUENZA Vaccine Consent 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 Number: (if available)
Medicare Number:	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		

I give permission for administration of vaccine and for my insurance company to be billed.

X _____ Date: _____

(Signature of patient, parent or legal guardian)

PLEASE FILL OUT BOTH SIDES ►►►►►►►►

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Place Photo Copy of All Insurance Cards Here:

Provider Name: Westford Health Department- Provider Address: 55 Main Street, Westford, MA 01886 **MDPH Provider PIN#** 11994

Gail Johnson, BSN, RN Public Health Nurse Jeff Stephens, Health Director

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For children 18 years of age and younger:

Is Vaccine for Children (VFC) Program eligible:

- ☐ 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

Is not VFC-eligible:

- ☐ Has health insurance and is not American Indian (Native American) or Alaska Native

Vaccine Screening Questions for Injection

Has this person ever received a flu vaccine?	Yes	No
Is this person allergic to eggs or egg protein, or thimerosal?	Yes	No
Has this person ever had Guillain-Barre Syndrome?	Yes	No
Has this person ever had a life-threatening reaction to a flu vaccine?	Yes	No

For Clinic/Office Use Only:

IIV4 Inactivated influenza vaccine, quadrivalent **IIV3** High Dose = Inactivated influenza vaccine, trivalent, high dose **aIIV3**=Fluad influenza vaccine, trivalent, senior dose =I**IV4- Flulaval** state supplied- **IIV4 Flumist** intranasal state supplied

Date of Service	Vax Type	Vax Mfgr	Lot No	Exp Date	Dose (mL)	State Supplied	Preserv Free	Injection Route (Circle)	Injection Site (Circle)	Date On VIS	Date VIS given
	IIV4 Fluzone (Quadrivalent)	Sanofi			0.5	No No	Yes Yes	IM	R Arm L Arm	8/7/15	
	Fluzone High Dose (IIV3-HD)	Sanofi			0.5	No	Yes	IM	R Arm L Arm	8/7/15	
	Fluad (aIIV3) Senior Dose	Seqirus	250792	4/30/19	0.5	No	Yes	IM	R Arm L Arm	8/7/15	
	IIV4 Flulaval 6 months older State Supplied	GSK	2D24J 4DY9K	6/20/2019 6/7/2019	0.5	Yes	Yes	IM	R Arm L Arm	8/7/15	
	IIV4 FluMist State Supplied	Astra Zeneca			0.2ml	Yes	Yes	Intranasal	Intranasal	8/7/15	

Signature of Nurse Administering Vaccine: _____

Provider Name: Westford Health Dept MDPH Provider PIN# 11994 Address: 55 Main St, Westford, MA 01886

Gai Johnson, BSN, RN Jeff Stephens, Health Director