2019-2020 INFLUENZA Vaccine Consent and Insurance Information Form
Adults Ages 19 and older

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:* 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:* Male ◯ Female ◯
Subscriber's Street Address: * (If different from address above)		
City: *	State: *	Zip: * Phone: * ( )
Patient Relationship to Subscriber:* ◯ 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, Public Health Director*

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Adults Ages 19 and older

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, Fluzone quadrivalent **IIV3** High Dose = Inactivated influenza vaccine, trivalent, high dose

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	Yes	IM	R Arm L Arm	08/15/2019	
	Fluzone High Dose (IIV3-HD)	Sanofi			0.5	No	Yes	IM	R Arm L Arm	8/15/2019	

Signature of Nurse Administering Vaccine: _____

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

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