2019 – 2020 INFLUENZA Vaccine Consent and Insurance Information Form

AGES 3 through 18

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: (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 **MDPH Provider PIN#** 11994

Provider Address: 55 Main Street Westford, Ma 01886

Gail Johnson, BSN, R.N. Public Health Nurse *Jeffrey Stephens, Public 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 IIV4 Flulaval state supplied- LAIV4 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 inactivated quadrivalent	Sanofi			0.5	Yes No	Yes	IM	R Arm L Arm R Leg L Leg	08/15/2019	
	IIV4 Flulaval Pre-filled 6 months on older STATE SUPPLIED	Glaxo SmithKline			0.5 ml	Yes	Yes	IM	R arm L arm R leg L leg	8/15/2019	
	LAIV4 State Supplied FluMist	AstraZeneca			0.2 ml	Yes	Yes	Intranasal	N/A	8/15/2019	

Signature of Nurse Administering Vaccine: _____

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