2017-2018 Flu 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 my insurance company to be billed.

X _____ Date: _____

(Signature of patient, parent or legal guardian)

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***Place Photo Copy of All Insurance Cards Here:**

Provider Name: _Marlborough Board of Health_____ MDPH Provider PIN#: ___11048_____

Provider Address: City of Marlborough, Board of Health, Lower Level, 140 Main St., Marlborough, MA, 01752_____

prm: 09.11.2017

2017-2018 Flu Insurance Information Form

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

I give permission for my child to receive the Influenza vaccine.

X _____ Date: _____

(Signature of patient, parent or legal guardian)

For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

1. Is the person to be vaccinated sick today — Yes No Don't know
2. Does the person to be vaccinated have an allergy to a component of the vaccine? — Yes No Don't know
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? — Yes No Don't know
4. Has the person to be vaccinated ever had Guillain-Barré syndrome? — Yes No Don't know

form completed by;_____ date: _____

form reviewed by : _____ date: _____

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For Clinic/Office Use Only:

Name: (Last, First, MI)	**Date of Birth:**	**Age:**

Date of Service	Vax Type	Vaccine Mfgr	Lot No	Exp Date	Dose (mL)	State Supplied (Circle)	Preserv Free*	Injection Route (Circle)	Injection Site (Circle)	Date On VIS	Date VIS Given
	IIV4	Sanofi Pasteur			0.25 0.5	Yes No	Yes No	IM	R Arm L Arm R Leg L Leg	8.7.15	
	Fluzone High Dose (IIV3-HD)	Sanofi Pasteur			0.5	No	Yes	IM	R Arm L Arm	8.7.15	

Printed Name of Vaccine Administrator: _____

Signature of Vaccine Administrator: _____

prm: 09.11.2017