# 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** **0.2 ml** | **Dose #1** **Dose #2** | **IM R Arm L Arm** **IM R Leg L Leg** ---------- **Intranasal** | **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? | ☐ | ☐ |

| **B. If the person to be vaccinated is between 2 and 49 years of age, the answers to the following questions will help us determine if FluMist is appropriate. Mark YES or No for each question.** | **YES** | **NO** |
|---|---|---|
| 1. Has the person been vaccinated with any vaccine (not just flu) within the past 30 days?<br><br>Vaccine: _____ Date given: month_____day_____year_____ | ☐ | ☐ |
| 2. Does the person have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood? | ☐ | ☐ |
| 3. Is the person on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)? | ☐ | ☐ |
| 4. Does the person have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)? | ☐ | ☐ |
| 5. Is the person pregnant or might she become pregnant within the next month? | ☐ | ☐ |
| 6. Does the person have close contact with someone who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)? | ☐ | ☐ |
| 7. Is the person to be vaccinated younger than 2 years? Or older than 49 years? | ☐ | ☐ |
| 8. If your child is younger than 5 years old, has a healthcare provider told you that your child had wheezing or asthma within the last 12 months? | | |

**C. If a child to be vaccinated is between 6 months and 8 years old.**
**Information to determine if your child should receive 0, 1 or 2 doses of flu vaccine.**

1. **Has your child ever received flu vaccine**? ☐ Yes ☐ No

2. How many total doses of flu vaccine has your child ever received **prior to July 1, 2019**?
☐ No Doses ☐ Only 1 dose ☐ 2 or more doses

3. Has your child received flu vaccine this flu season **since July 1, 2019**? ☐ No ☐ Yes
If yes, please tell us the number of doses and dates of vaccination below : ☐ ☐ 1 Dose ☐ 2 Dose
**Dose 1**: Date received: month____ day____ 2019 **Dose 2**: Date received: month____ day____ 2019.

**********

For Clinic/Office Use Only
Place Photo Copy of Card Here: