

# 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: * <i>(If different from address above)</i>						
City:*	State:*	Zip: *	Phone:*			
Patient Relationship to Subscriber: (Circle)* Spouse Child Other						

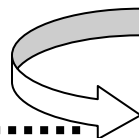
**For children 18 years of age and younger:**

<input type="checkbox"/> Is enrolled in Medicaid (includes MassHealth and HMOs, etc., if enrolled through Medicaid) <input type="checkbox"/> Does not have health insurance <input type="checkbox"/> Is American Indian (Native American) or Alaska Native <input type="checkbox"/> Has health insurance and is not American Indian (Native American) or Alaska Native
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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	Dose #1	IM R Arm L Arm	8/15/19
			0.2 ml	Dose #2	IM R Leg L Leg	
----- Intranasal						

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: \_\_\_\_\_

<b>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.</b>	<b>YES</b>	<b>NO</b>
1. Does the person to be vaccinated have an allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the person to be vaccinated have an allergy to gentamicin, neomycin, polymixin or gelatin?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is the person to be vaccinated sick today?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the person to be vaccinated ever had a serious reaction to a previous dose of vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the person to be vaccinated had Guillain-Barre Syndrome within 6 weeks of receiving a flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>

<b>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.</b>	<b>YES</b>	<b>NO</b>
1. Has the person been vaccinated with any vaccine (not just flu) within the past 30 days?  Vaccine: _____ Date given: month_____day_____year_____	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is the person on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the person have or care for someone with a weak immune system? (for example: HIV, cancer, or medications such as steroids or those used to treat cancer)	<input type="checkbox"/>	<input type="checkbox"/>
5. Is the person pregnant or might she become pregnant within the next month?	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>
7. Is the person to be vaccinated younger than 2 years? Or older than 49 years?	<input type="checkbox"/>	<input type="checkbox"/>

<b>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.</b>
1. <b><u>Has your child ever received flu vaccine?</u></b> <input type="checkbox"/> Yes <input type="checkbox"/> No
2. How many total doses of flu vaccine has your child ever received <b><u>prior to July 1, 2019?</u></b> <input type="checkbox"/> No Doses <input type="checkbox"/> Only 1 dose <input type="checkbox"/> 2 or more doses
3. Has your child received flu vaccine this flu season <b><u>since July 1, 2019?</u></b> <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please tell us the number of doses and dates of vaccination below : <input type="checkbox"/> 1 Dose <input type="checkbox"/> 2 Dose <b>Dose 1:</b> Date received: month____ day____ 2019 <b>Dose 2:</b> Date received: month____ day____ 2019.

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