Seasonal Influenza Vaccine 2020 – 2021 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 2020-2021 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: _____

(Signature of patient, parent or legal guardian)

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Vax Type / Injection Route **Manufacturer**	**Lot No.** **Expiration Date**	**Preservative Free** **State Supplied**	**Dose** (Circle)	**Dose No.** (Circle)	**Injection Site** (Circle)	**Date on VIS**
			0.5 ml	**Dose #1** **Dose #2**	**R Arm L Arm** **R Leg L Leg**	**8/15/19**

Provider Name & Address: Wenham Board of Health, 138 Main Street, Wenham, MA 01984 MDPH Provider PIN # : 15198

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. Is the person to be vaccinated sick today?	☐	☐
2. Has the person to be vaccinated ever had a serious reaction to a flu vaccine in the past?	☐	☐
3 Does the person to be vaccinated have an allergy to eggs?*	☐	☐
4. Does the person to be vaccinated have an allergy to gentamicin, neomycin, polymixin or gelatin?	☐	☐
5. Has the person to be vaccinated had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks of receiving a flu vaccine?	☐	☐

*Please note:

- Experts now say any flu vaccine can be administered to those with a serious allergic reaction to eggs, including anaphylaxis. However, such individuals should be vaccinated in an inpatient or outpatient medical setting where **vaccine administration can be supervised by a healthcare provider who is able to recognize and manage severe allergic conditions**.
- Children with hives only after egg exposure can be vaccinated with any flu vaccine in any usual immunization setting.

B. 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 **before July 1, 2020**?

   ☐ No Doses ☐ Only 1 dose ☐ 2 or more doses

3. Has your child received flu vaccine this flu season **since July 1, 2020**? ☐ 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____ 2020 **Dose 2**: Date received: month____ day____ 2020.

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Place Photo Copy of Card Here: