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)

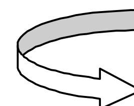
If person getting vaccinated is not the subscriber, please complete the following:

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 have been given a copy and have read, or had explained to me the 2017-2018 Vaccine Information Statement for the Seasonal Influenza vaccine and understand the risks and benefits. I understand that children younger than 9 years of age may need 2 doses of vaccine. 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)



TURN FORM OVER

QUESTIONS ON BACK

For Clinic/Office Use Only:

Vax Type	Vaccine Mfgr	Lot No	Exp. Date	Dose (mL)	Dose No. (Circle)	State Supplied	Preserv Free	Injection Route	Injection Site (Circle)	VIS Date
Flulaval (IIV4)	GSK	PN75E	05/31/2018	0.5	Dose #1 Dose #2	Yes	Yes	IM	R Arm L Arm	08/07/2015

Signature of Vaccinator: ____ Date Vaccine & VIS Given: _______________

Provider Name & Address: City of Gloucester Health Department, 3 Pond Rd., Gloucester, MA 01930 MDPH Provider PIN#: 10580

2017 – 2018 Flu Insurance Information Form

Information about the person to receive vaccine *(please print* ***again****):*

Name: (Last, First, MI)*	Age*	Sex: (Circle)* Male Female

Please answer the following:

A. If your child is 8 years old or younger:	
Did he/she previously receive **2** or more total doses of any flu vaccine as of July 1, 2017? The **2** previous doses do not need to have been given during the same season or consecutive seasons.	
YES: _____	child needs only one dose of seasonal flu vaccine this season.
NO: _____	child should be given 2 doses of seasonal flu vaccine, 4 weeks (28 days) apart.
Not certain: ____	child with uncertain vaccine history should be given 2 doses of seasonal flu vaccine, 28 days apart.

Persons who have reached their 9th birthday need only 1 dose of seasonal flu vaccine this season, regardless of their flu vaccination history.

If your child is 8 years old or younger, and has already received one dose of 2017 – 2018 seasonal influenza vaccine, please tell us the date of vaccination.	
Dose 1	Date Received: month ________ day ________ year _________
Dose 2	Date Received: month ________ day ________ year _________

B. The following questions will help us to determine if the person to be vaccinated can get the 2017–2018 seasonal influenza vaccine. 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. Has the person to be vaccinated ever had a serious reaction to a previous dose of vaccine?	☐	☐
4. Has the person to be vaccinated ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks of receiving a flu vaccine?	☐	☐

Answer 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