Injectable FLU VACCINE

FLU VACCINE 2021-2022

NORTH ATTLEBORO BOARD OF HEALTH

Date ___________________________

Name ____ Age __________________
Please print

Have **you**/your child had a previous Flu shot? yes _______ When?_____________ no ______

Have **you**/your child ever had a serious reaction to flu shot in the past? yes _____ no _____

If yes, what
happened:____

Are **you**/your child sick today? yes ______ no__________

Do **you**/your child have an allergy to eggs? yes_______ no _________

Have **you/**your child ever had Guillain-Barré Syndrome? yes ____ no _____ don't know _____

Do **you**/your child have an allergy to Latex? yes ____ no _____

I have read and received the vaccine information statement (VIS) explaining the benefits and risks of the influenza vaccine and have had my questions answered.

PLEASE FILL OUT OTHER SIDE OF THIS FORM (print clearly)

ATTACH A COPY OF YOUR INSURANCE CARD or FILL OUT ALL THE INSURANCE INFO

2021-2022 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. I give permission to be vaccinated.

X ____ Date: ________________

(Signature of patient, parent or legal guardian)

For children 18 years of age and younger: Please check one of below

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

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*** For Clinic/Office Use Only:**

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			0.5	Yes No	Yes No	IM	R Arm L Arm R Leg L Leg	8/6/21	
	IIV4-HD			0.7	No	Yes No	IM	R Arm L Arm R Leg L Leg	8/6/21	

Provider Name: __North Attleboro Board of Health______________________ MDPH Provider PIN#: ____11188_______

Provider Address: _43 South Washington Street North Attleboro MA 02760________________________________

Signature of Vaccine Administrator:____Date:____________