2017-2018 Seasonal Flu Insurance Information Form

For children 18 years of age and younger:
Is Vaccine for Children (VFC) Program eligible?
___ is enrolled in Medicaid (includes MH& HMOs 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

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*	ST*	Zip *	Phone* ( )

Insurance Information:

Insurance Co*	Member ID#*	Group ID Number:	Medicare Number	Medicare Primary? Y N

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

Subscribers Name (Last, First , MI)*	Date of Birth *	Sex (Circle)* M F

Street Address (if different from above) *	City*	ST*	Zip*	Phone* ( )
Patient relationship to Subscriber (circle)*	Spouse	Child		Other

You or your child's information will be entered into the Massachusetts Immunization Information System (MIIS) as required by law. The MIIS is a confidential, computerized statewide immunization tracking system. Immunization records may be shared with health care providers, school nurses, local boards of health and state agencies concerned with immunization. You can choose to restrict who may see your shot information in the MIIS at any time. For more information contact Ruth Mori, RN at the Wayland Board of Health (508-358-3617).
I have been offered and understand the vaccine information statement for the vaccine to be given. I give permission to be vaccinated or for my child to be vaccinated. Children younger than age 9 years of age may need 2 doses of vaccine. I give permission to bill my insurance company.

X _____ (Signature of patient, parent or legal guardian)Date:_____

Date of Service	Vax Type	Vaccine Mfg.	Lot No	Exp Date	Dose (ml)	State Supplied (Circle)	Preserv Free (Circle)	Injection Route	Injection Site (Circle)	Date On VIS	Date VIS Given
	FLU or HD				0.5	Y N	Y N	IM	R Arm L Arm R Leg L Leg	8/7/15	Same DOS
	PNU-PCV13 PNU-PPSV				0.5	Y N	Y N	IM	R Arm L Arm	11/5/15 4/24/15	Same DOS Same DOS

X_____(Signature of vaccine administrator)

Provider name: **Wayland** Board of Health 41 Cochituate Road Wayland, MA 01778 MDPH Pin# **14726**

Screening checklist for Inactivated Injectable Influenza Vaccination

For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is a reason we should not give you or your child the inactivated injectable influenza Vaccination. If you answer "yes" to any question, it does not necessarily mean that you or your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	**No**	**do not know**
1. Is the person to be vaccinated sick today?			
2. Does the person to be vaccinated have an allergy to a component of the vaccine?			
3. Has the person to be vaccinated ever had a serious reaction To influenza vaccine in the past?			
4. Has the person to be vaccinated ever had Guillain-Barre syndrome?			

Form Completed by: _____Date

Form Reviewed by:_____Date