## 2018-2019 Seasonal Flu Insurance Information Form

Is not Vaccine for Children eligible: has health insurance a  Information about the person to receive vaccine (please print): *REQU  Name: (Last, First, MI)*			,			merican	) or Alaska	Sex: (Circle)*			
Street Address*			City*		ST*		*	Phone*			
Insurance Information:  Insurance Co*  Member ID#*			Group ID Number:			Medicare Number		Medicare Prin Y N		rimary?	
		nplete the fol	lowing:	Date of Bi	irth * m/c	І/у				Sex C	ircle* F
Street Address If different from address above*			City*		ST*	Zip	*	Phone*			
Patient relationship to Subscriber (circle)*			е		Child			Other			
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DOS	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
	IIV4 or HD				0.5	Y N	Y N	IM	Arm R L Leg R L	8/7/15	= DOS
	PCV13 or				0.5			IM	Arm R	11/5/15	= DOS
PP	PPSV23				0.5 Y N	YN	YN		Arm L	4/24/15	= DOS

X	(Signature of vaccine administrator)

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

## **Screening checklist for Injectable 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 injectable 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?	Υ	N	DNK
2. Does the person to be vaccinated have an allergy to a component of the vaccine?	Υ	N	DNK
<b>3.</b> Has the person to be vaccinated ever had a serious reaction to a vaccine in the past?	Υ	N	DNK
4. Has the person to be vaccinated ever had Guillain-Barre syndrome?	Υ	N	DNK
Form Completed by:	Date		
Form Reviewed by:	Date		

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