2020-2021 Flu Insurance Information Form – WELLESLEY, MA (Adult)

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 insurance subscriber/policy holder, 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 to receive an influenza vaccine and/or for my insurance company to be billed.
Your 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.

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

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For Clinic/Office Use Only: **Signature of Vaccine Administrator:** _____

Date of Service	Vax Type	Vax Mfgr	Lot No	Exp Date	Dose (mL)	State Supplied (Circle)	Preserv Free* (Circle)	Injection Route	Injection Site	Date On VIS	Date VIS Given
					0.5	YES NO	YES NO	IM	L ARM R ARM	8/15/19	Same as date of service

Provider Name: WELLESLEY HEALTH DEPARTMENT/BOARD OF HEALTH MDPH Provider PIN#: 11887

Provider Address: 90 WASHINGTON ST, WELLESLEY, MA 02481

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Screen Checklist for Contraindications to Inactivated Injectable Influenza Vaccination

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

1. Is the person to be vaccinated sick today?	**YES**	**NO**
2. Does the person to be vaccinated have an allergy to a component of the vaccine?	**YES**	**NO**
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	**YES**	**NO**
4. Has the person to be vaccinate ever had Guillain- Barre syndrome?	**YES**	**NO**

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

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