2020-2021 Flu Insurance Information Form & Vaccine Administration Record

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

Last Name*	First Name*	MI	Date of birth: * _____ / _____ / _____ Month Day Year	Age*	Sex:*
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:*
Subscriber's Street Address:* (If different from address above)		
City:*	State:*	Zip: *	Phone:*
Patient Relationship to Subscriber: (Circle)* ☐ Spouse ☐ Child ☐ Other		

For children 18 years of age and younger:

Is Vaccine for Children (VFC) Program eligible:
- ☐ Is American Indian (Native American) or Alaska Native
- ☐ Is enrolled in Medicaid (includes MassHealth and HMOs etc. if enrolled through Medicaid)
- ☐ Does not have health insurance

Is not VFC-eligible:
- ☐ Has health insurance and is not American Indian (Native American) or Alaska Native

I give permission for my insurance company to be billed.

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/Date VIS Given	Vax Type	Vaccine Mfgr	State Supplied	Preserv Free*	Lot No	Exp Date	Dose (mL)	Injection Route	Injection Site (Circle)	Date On VIS
	Place sticker here							IM	R Arm L Arm	8/15/19

Provider Name: Newton Health and Human Services Department MDPH Provider PIN#: 11223
Provider Address: 1000 Commonwealth Ave, Newton, MA 02459

Newton HHS 2020-2021 Flu Screening Questions and Consent Form

Each person must have their own forms

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

Last Name*	First Name*	MI	Date of birth: *
			_____ / _____ / _____ Month Day Year

Flu Screening Questions

	Yes	No
1. Have you/your child ever had a serious reaction to a flu vaccine in the past?		
2. Have you/your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		
3. Have you/your child ever had a serious allergic reaction after eating eggs?		
4. Do you/your child have an allergy to gentamicin, neomycin, polymixin, or gelatin?		

A "YES" to questions 1 and 2 indicates you/your child cannot receive this vaccine at our clinic. A "YES" to questions 3 and 4 indicates you/your child *might* be able to receive this vaccine at our clinic depending on the available formulations – please call 617-796-1420 for more information. If you are not sure of the answers to these questions, contact your/your child's health care provider.

COVID-19 Screening Questions

	Yes	No
1. Do you/your child have any of the following symptoms: fever or feeling feverish, chills, cough (not due to other known cause), difficulty breathing or shortness of breath, new loss of taste or smell, sore throat, headache, muscle aches or body aches, nausea/vomiting or diarrhea, fatigue, nasal congestion/runny nose (not due to other known causes)?		
2. Have you/your child been told by a public health official to isolate or quarantine?		
3. In the last 14 days, have you/your child traveled anywhere that isn't on the Massachusetts list of lower-risk states and did not get a valid negative PCR test (no longer than 72 hours before returning or after your arrival)?		

If you answered "YES" to any question, you may not attend our clinic unless the answer has changed to "NO" by the day of the clinic. If any of your answers change from "NO" to "YES" on the day of the clinic, please call 617-796-1420 to reschedule your appointment.

I have read the Vaccine Information Statement for the flu shot and understand the risks and benefits. I GIVE CONSENT for me/my child to get vaccinated with this vaccine.

SIGNATURE

DATE: _____

For all children 6 months through 8 years old:

Children in this age group should receive 2 doses of the 2020-2021 seasonal influenza vaccine at least 4 weeks apart unless they received at least 2 doses of any seasonal influenza vaccine prior to July 1, 2020.

Contact the child's primary health care provider to receive a second dose or visit www.newtonma.gov/flu for additional clinics.

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Massachusetts law (M.G.L. c. 111, Section 24M) requires providers to report immunization information to a computerized immunization registry known as the **Massachusetts Immunization Information System (MIIS)**. The MIIS stores immunization records for you and your healthcare provider and can help prevent outbreaks of disease like measles and the flu. All information in the MIIS is kept secure and confidential. The MIIS allows information to be shared with health care providers, school nurses, local boards of health, and state agencies concerned with immunization. You have the right to object to the sharing of your immunization information across providers in the MIIS. For more information, please ask your healthcare provider, visit the MIIS website at www.mass.gov/dph/miis or contact the Massachusetts Immunization Program directly at 617-983-6800 or 888-658-2850.