

2020-2021 Flu Vaccine 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 information as possible.

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

Name: (Last, First, MI)*	Date of Birth: * ____/____/____ Month Day Year	Age: *	Sex: (circle)* Male Female
Street Address: *			Phone: *
City: *	State: *	Zip: *	

Insurance Information: Include the whole Member ID including any letters or dashes

Name of Insurance Company: *	Member ID: *	Group ID (if applicable): *
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If person getting vaccinated is not the subscriber, please complete the following:

Name: (Last, First, MI)*	Date of Birth: * ____/____/____ Month Day Year	Age: *	Sex: (circle)* Male Female
Street Address: *			Phone: *
City: *	State: *	Zip: *	
Patient Relationship to Subscriber: * Spouse Child Other: _____			

I have been given a copy and have read, or had explained to me the 2020-2021 Vaccine Information Statement (VIS) for the Seasonal Influenza vaccine and understand the risks and benefits. I understand that children younger than 9 years of age may need 2 doses of vaccine. I voluntarily give consent for the person named above to be vaccinated. I give permission to bill my/his/her health insurance.

X _____ (Signature of Patient or Guardian) Date: _____

Turn over to complete this form



For Clinic/Office Use Only:

Vax Type	Vaccine Mfr.	Lot #	Exp Date	Dose (mL)	State Supplied	Preserv Free	Injection Route	Injection Site	VIS Date	Date of Service
Flulaval	GSK	5X5J2	6/30/21	.5	Y	Y	IM	L Arm R Arm	8/15/19	
LAIV4	Astra Zeneca	MH2201	12/16/20	.2	Y	Y	Intranasal	N/A	8/15/19	
Flucelva x	Sequius			.5	Y	Y	IM	L Arm R Arm	8/15/19	

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

Name: (Last, First, MI)*	Age:*	Sex: (circle)* Male Female
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Answer for children 18 years of age and younger:

<input type="checkbox"/> Is Vaccine for Children (VFC) Program eligible: <ul style="list-style-type: none"> 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
<input type="checkbox"/> Is not VFC eligible: <ul style="list-style-type: none"> Has health insurance and is not American Indian (Native American) or Alaska Native

A. Please answer the following to determine the patient's vaccination eligibility:

Please mark YES or NO for each question	YES	NO
1. Does the person to be vaccinated have an allergy to eggs?		
2. Does the person to be vaccinated have an allergy to gentamicin, neomycin, polymyxin or gelatin?		
3. Has the person to be vaccinated ever had a serious reaction to a previous dose of vaccine?		
4. Has the person to be vaccinated ever had Guillain-Barre Syndrome within 6 weeks of receiving a flu vaccine?		

B. There are two methods of administering the 2020-2021 seasonal influenza vaccine, intramuscular and intranasal. Your answers to the following questions will help us determine which form of vaccine is best for you/your child:

Please mark YES or NO for each question	YES	NO
1. Has the person been vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____ Dated Given: ____/____/____		
2. Does the person have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves or blood?		
3. Is the person on long-term aspirin, salicylate-containing therapy or aspirin-containing therapy (for example does your child take aspirin every day)?		
4. Does the person have a weak immune system (for example, from HIV, cancer or medications such as steroids or those used to treat cancer)?		
5. Is this person pregnant or might she become pregnant within the next month?		
6. Does the person have close contact with someone who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?		
7. Is the person to be vaccinated younger than 2 years? Or older than 49 years?		
8. If your child is younger than 5 years old, has a healthcare provider told you that he/she had wheezing or asthma within the last 12 months?		