2018-2019 Flu and Pneumo 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 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*

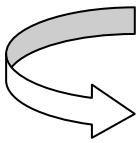
Name of Insurance Company:*	Member ID Number:*	Group ID Number: (if available)
Medicare Number:	Is Medicare Primary? Yes No	Is Subscriber Retired? Yes No

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 have been given a copy and have read or had explained to me the Vaccine Information Statement for the 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 for my/his/her insurance company to be billed.**

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



TURN FORM OVER

QUESTIONS ON BACK

****** Massachusetts Immunization Information System (MIIS) keeps track of immunization records for you and your family. The goal is to make your records up-to-date and available when you need them. The information on this sheet will be uploaded to MIIS. You have the right to limit who can see your information by completing an "Objection or Withdrawal of Objection to Data Sharing" form.

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For Clinic/Office Use Only:

Date of Service	Vax Type	Vaccine Mfgr	Lot No	Exp Date	Dose (mL)	State Supplied (Circle)	Preserv Free (Circle)	Injection Route	Injection Site (Circle)	VIS Date	Date VIS Given
	IIV4				0.5	Yes / No	Yes / No	IM	R Arm /L Arm		
	LAIV4	AstraZeneca			0.2	Yes	Yes	Intranasal	NA		
	Flucelvax (ccIIV4)	Seqirus			0.5	Yes	Yes	IM	R Arm /L Arm		
	Fluzone High Dose (IIV3-HD)	Sanofi Pasteur			0.5	No	Yes	IM	R Arm /L Arm		

Signature of Vaccine Administrator: _____

Provider Name: Peabody Health Department **Provider Address:** 24 Lowell St, Peabody, MA 01960 **MDPH Provider PIN#:** 11306

2018-2019 Flu and Pneumo Insurance Information Form

For children 18 years of age and younger:

Is Vaccine for Children (VFC) Program eligible:
- ☐ 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

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

A. The following questions will help determine if the person to be vaccinated can get the 2018-2019 influenza vaccine.	**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, polymixin 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-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks of receiving a flu vaccine?		

B. There are two methods of administering the 2018-2019 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.	**YES**	**NO**
1. Has the person been vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: month_____day_____year_____		
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 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 the 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 your child had wheezing or asthma within the last 12 months?		

Place Photo Copy of All Insurance Cards Here:

Provider Name: Peabody Health Department **Provider Address:** 24 Lowell St, Peabody, MA 01960 **MDPH Provider PIN#:** 11306