2020-2021 Flu Insurance Information and Consent Form

Information about the person to receive vaccine (please complete and print): *Required Fields

Name: (Last, First, MI)*	Date of birth: * ____ ____ ____ Month Day Year	Age*	Sex: (Mark X)* 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? (Mark X) Yes No	Is Subscriber Retired?(Mark X) 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: (Mark X)* Male Female
Subscriber's Street Address:* (If different from address above)		
City:*	State:*	Zip: *	Phone:*
Patient Relationship to Subscriber: (Mark X)* Spouse Child Other		

I give permission for my insurance company to be billed and for the flu vaccine to be administered.

X _____ Date: _____

(Signature of patient, parent or legal guardian)

Are you feeling ill today? Yes or No
Have you travelled outside of Massachusetts within the last two weeks? Yes or No
Have you been around anyone who tested positive for Covid 19 within the last two weeks? Yes or No
Are you allergic to eggs, gentamicin, neomycin, polymyxin or gelatin? Yes or No
Have you ever had the flu shot before? Yes or No
Have you ever had Guillain Barre Syndrome? Yes or No

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For Clinic/Office Use Only:

Signature of Vaccine Administrator: _____

Date of Service	Vaccine Type	Vaccine Mfgr	State Supplied	Preserv Free	Lot No	Exp Date	Dose (mL)	Injection Route (Circle)	Injection Site (Circle)	Date On VIS	Date VIS Given
	Fluzone HD-IIV4	Sanofi Pasteur	No	Yes	UJ453AA UJ484AA	06/30/21	**0.7**	**IM**	**R Arm L Arm**	**8/15/19**	
	Fluarix Quad IIV4	GSK	No	Yes	N549A	06/30/21	**0.5**	**IM**	**R Arm L Arm**	**8/15/19**	
	Flulaval Quad IIV4	GSK	YES	Yes	494S5	06/30/21	**0.5**	**IM**	**R Arm L Arm**	**8/15/19**	
	Flublok RIV4	Sanofi Pasteur	No	Yes	UJ446AA	03/18/21	**0.5**	**IM**	**R Arm L Arm**	**8/15/19**	

Provider Name: Marion Board of Health

MDPH Provider PIN#: 22213

Provider Address: 2 Spring Street, Marion, MA 02738