

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: *	Age*	Sex: (Mark X)* Male Female
		_____ Month Day Year	
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: *	Sex: (Mark X)* Male Female
		_____ Month Day Year
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

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
9/26/20	Fluzone HD	Sanofi Pasteur	No	Yes	UJ453AA	06/30/21	0.5	IM	R Arm L Arm	8/15/19	9/26/20
9/26/20	Flulaval Quad	GSK	No	Yes	99J23	6/30/21	0.5	IM	R Arm L Arm	8/15/19	9/26/20
9/26/20	Flulaval Quad State	GSK	YES	Yes	2SM24	06/30/21	0.5	IM	R Arm L Arm	8/15/19	9/26/20
9/26/20							0.5	IM	R Arm L Arm	8/15/19	9/26/20

Provider Name: Barnstable County Department of Health & Environment MDPH Provider PIN#: 14315

Provider Address: 3195 Main Street, Old Jail Bldg, Barnstable, MA 02630