2021-2022 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 as possible using existing information.

Name: (Last, First, MI)*				D	ate of bi	oirth: *			Age*	Sex: (0	circle)*	
					<u> </u>		Day	Year		x	Male	Female
	Street Ac	ldress:*							if.	'		
City:*			S	tate: *	:* Zip:*			P (Phone:*			
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surance Information: Include the whole mem Name of Insurance Company:*					Member ID Number:*			at are pai	Group ID Number: (if available)			
Medicare Number:				Is	Is Medicare Primary? Yes No				Is Subscriber Retired? Yes No			
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Subscri	oer's Name	: (Last, First	, MI)*					Subscriber's Date of Birth			, ,	
							Month Day Year			Male Female		male
Subscri	per's Street	Address:* (If different f	rom address	s above)							
City:*			St	State:* Zip: *			* Phone:*				3, - 1	
Patient Relationship to Subscriber: (Circle)* Spou				ouse	Child Other							
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x	(Signature	of patient, p	arent or leg	al guardian)				_ Date):		_
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Date of	Vax Type	Vax Mfgr	Lot No	Exp Date	Dose (mL)	State	100	reserv	Injection Route	Injection S		Date V
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vider A	ddress:	19 Washi	ngton Stree	et, Sherborn,	MA 01770)						
	of Vaccin							4		Date:		

Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination

PATIENT NAME	_
DATE OF BIRTH /	

For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked.

If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is the person to be vaccinated sick today?			
2. Does the person to be vaccinated have an allergy to an ingredient of the vaccine?			
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?			
4. Has the person to be vaccinated ever had Guillain-Barré syndrome?			
FORM COMPLETED BY	DATE		
EORM REVIEWED BY	DATE		