2018 -2019 Flu Vaccine Insurance and Consent Information Form

School ____________________________________ **Grade**______ ***Allergies:*** ___________________________

Information about person receiving vaccine. Please **PRINT** legibly. **Do Not Use Nicknames** *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 #: (if available)

If person getting vaccinated is not the subscriber, 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			

Information to determine if your child should receive the 2018-2019 seasonal flu vaccine. Please check YES or NO for each question. If you answer "YES" to one or more of the 4 questions, your child will not be able to get flu vaccine in school. If you are not sure of the answers, check with your child's healthcare provider.

	NO	YES
1. Does your child have an allergy to eating eggs?		
2. Does your child have an allergy to gentamicin or gelatin?		
3. Has your child ever had a serious reaction to a flu vaccine in the past?		
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		

CONSENT FOR CHILD'S VACCINATION: I have read or had explained to me the Vaccine Information Statement for the Influenza vaccine and I understand the risks and benefits.

I give permission to receive vaccine and for my insurance company to be billed.

X ____ Date: ________________

(Signature of patient, parent or legal guardian)

For children 18 years of age and younger:

____ 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
____ Has health insurance and is not Native American or Alaska Native

For Clinic/Office Use Only: Signature of Vaccine Administrator: ____

Date of Service	Vax Type	Vaccine Mfgr	Lot No	Exp Date	Dose (mL)	State Supplied	Preserv Free	Injection Route	Injection Site (Circle)	Date On VIS	Date VIS Given
	Flulaval	GSK			0.5	Yes	Yes	IM	R Arm L Arm	8/7/15	
	LAIV4	AstraZeneca			0.2	Yes	Yes	intranasal	N/A	8/7/15	

Provider and Address: Andover Health Dept., 36 Bartlet Street, Andover MA 01810 **MDPH Pin: 10049**