

2016 - 2017 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: (MM/DD/YYYY)*	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)*
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If person getting vaccinated is not the subscriber, please complete the following:

Subscriber's Name: (Last, First, MI)* ,	Subscriber's Date of Birth: (MM/DD/YYYY)*	Sex: (Circle)* Male Female
Subscriber's Street Address:*		
City:*	State:*	Zip:*
Patient Relationship to Subscriber: (Circle) * Spouse Child Other		

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)

Is American Indian (Native American) or Alaska Native

Does not have health insurance

Is not VFC-eligible:

Has health insurance and is not America Indian (Native American) or Alaska Native

Screening Questions:

- Has this person ever received a flu vaccination? YES NO
- Is your child allergic to eggs or egg protein, or thimerosal? YES NO
- Has your child ever had Guillain-Barre syndrome? YES NO
- Has your child ever had a life threatening reaction to flu vaccine? YES NO

- I give permission for my insurance company to be billed.
- I have read the Vaccine Information Statement for Flu Vaccine Injection and understand the risks and benefits and
- I give permission for the Westford Health Department to administer Flu Vaccine Injection (injectable only) to my child listed above.

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

(Print Parent/guardian name)

Daytime Parent Phone: _____

Child's School: _____ Grade: _____ Teacher or Cluster: _____ If K circle: **AM PM**

Child's Primary Care Provider (PCP) _____ PCP Phone: _____

If you sign your child up for this program and he/she receives the vaccine at another venue (ie. doctor's office) after you've registered but before the clinic dates, please contact the Health Dept. at 978-692-5509 to have him/her removed from our list.

For Clinic/Office Use Only:

Date Vax given:	Vax Type	Vax Manufacturer	Exp. Date / Lot NO	Dose	State Supplied	Preserv Free	Injection Site	Date On VIS	Date VIS given
	(IIV4) quadrivalent flu vaccine Fluzone	Sanofi Pasteur		0.5ml	Yes	Yes			
	Flucelvax (IIV4)	Seqirus		0.5ml	Yes	Yes			

Clinic Site Name: **Westford Health Department** MDPH Provider PIN#: **11994**

Clinic Address: **55 Main St Westford, MA 01886** Phone#: **978-692-5509**

Signature of Vaccine Administrator: _____ Date: _____

MAIL /Bring form to the Health Dept., 55 Main St. 2nd Floor