



Flu Vaccine Immunization Record CHILD

PLEASE PRINT

PLEASE PRINT NAME EXACTLY AS IT APPEARS ON INSURANCE CARD

		(Last)	(First)	(MI)	Birth date:	Sex:	
Child's Name:					/ /	Male	Female
St address:					age:	Phone:	
City:					State:	Zip:	
Mailing address if diff:							
City:					State:	Zip:	
Contact info if diff than above:							
Insurance information:				I do not have insurance			
BC/BS MA; Harvard Pilgrim;Aetna;Tufts;Fallon;BMC;NHP;Health New England;Unicare, MassHealth							
Insurance Name: _____				Is subscriber employed? Yes or No			
Policy number: _____				Group number: _____			
Subscriber DOB: / /				Subscriber Sex: F M			
Subscriber Name: _____							
Patient relationship to Subscriber: Please Circle Spouse Child Self							
My child MAY MAY NOT have flumist (nasal spray) (ages 2-19)							
Is your child allergic to eggs NO YES				Is your child allergic to Thimerosal (mercury) NO YES			
Is your child ill today NO YES				Has your child had the Flu Shot before NO YES			
Is your child allergic to latex NO YES				Has your child ever had Guillian Barre Syndrome NO YES			
<input type="checkbox"/> Is American Indian (Native American) or Alaska Native							
<input type="checkbox"/> Has health insurance and is not American Indian (Native American) or Alaska Native							
<input type="checkbox"/> Is enrolled in Medicaid (includes MassHealth and HMO's etc if enrolled through Medicaid)							
**FOR FLUMIST ONLY:		Does your child live with someone who is immune suppressed				NO YES	
Does your child have diabetes; or chronic illness: NO YES				Is your child pregnant: NO YES			
Does your child use a rescue inhaler : NO YES							

***** If you answered yes to any of the flumist only questions, your child will receive the IM dose of vaccine**

By signing below I am giving my permission for my Insurance to be billed and confirm that I have been given a copy and have read or have had explained to me the information on the flu vaccine information sheet.

8/7/2015

Signature of person to receive vaccine or that persons guardian _____
Date

DO NOT WRITE BELOW THIS LINE

Admin site: RD LD Nasal Nurses name: _____ Date administered: _____
Vaccine Vaccine
Name: _____ Manufacturer: _____ Lot # _____

Provider name: VNA of Cape Cod, Inc
Clinic/office address: 255 Independence Drive, Hyannis MA 02601 MDPH Provider PIN # _____

State supplied? Y or N Perserv Free? Y or N name/location clinic

Your signature above authorizes the release of protected health information pertaining to treatment, payment and operations necessary to this billing process, physicians, medical facilities, contracting provider, and community agencies involved in your care, quality review activities (internal and external, including regulatory and accrediting organizations), and release of outcome information to the state and center for Medicare and Medicaid Services, and Joint commission on Accreditation of Health Care Organizations.