Arlington Board of Health

Seasonal Flu Vaccination for Adults
2016-2017 Insurance Information Form

Information about the person receiving the vaccine (please print): *Required Fields

Name: (Last, First, MI)* Please use full first name	Date of Birth: * _____ _____ _____ Month Day Year	Age*	Gender: (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*

Primary Insurance Provider:*	Member ID #:*_____ Group Id #: _____ (If applicable)	**Place a copy of the front of your insurance card(s) here**
Name of Secondary Insurance:	Member ID #:*_____ Group Id #: _____ (If applicable)	

If person receiving vaccine is not the subscriber, please complete the following:

Subscriber's Name: (Last, First, MI)*	Subscriber's Date of Birth: * _____ _____ _____ Month Day Year	Gender: (Circle)* Male Female
Subscriber's Street Address:* (If different from address above)		
City:*	State:* Zip: *	Phone:* ( )
Patient Relationship to Subscriber: (circle)* Spouse Child Other:_____		

I give permission for myself to receive the vaccine, for vaccination information to be included in the Massachusetts Immunization Information System (MIIS)*, and for my insurance company to be billed. **Please see reverse side for MIIS details.*

X _____ Date: _____
(Signature of person receiving vaccine or their legal guardian)

********** **For Clinic/Office Use Only** **********

Vax Type	Vax Mfgr	Lot No	Exp Date	Dose (mL)	State Supplied	Preserv Free	Injection Route (Circle)	Injection Site (Circle)	Date On VIS	Date VIS Given 2016
☐ IIV4				0.50	NO	Yes No	IM	R Arm L Arm	8/7/15	
☐ IIV3				0.50	NO	Yes No	IM	R Arm L Arm	8/7/15	

Clinic Site Name/Address: Arlington Board of Health, 27 Maple Street, Arlington, MA 02476
MDPH Provider PIN#: 11828 **Vaccine Administrator Initials**: _____ **Date of Service**: _____/_____/2016

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The following questions will determine if you can receive the Seasonal Flu Vaccine. Please mark YES or NO for each question.

If you answer "YES" to one or more of these questions, you will not be able to receive the flu vaccine at this clinic. If you answer "NO" to the following questions, you will receive the vaccine unless a concern arises following additional screening. If you are not sure of the answers to these questions, please check with your healthcare provider.

Information about the person receiving the vaccine:	**YES**	**NO**
1. Do you have a serious allergy to eggs? *A serious allergy includes signs and symptoms similar to anaphylactic shock*	↑	↑
2. Do you have a serious allergy to gentamicin, neomycin, polymixin or gelatin?	↑	↑
3. Have you ever had a serious reaction to a previous dose of flu vaccine?	↑	↑
4. Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	↑	↑

Information about the person receiving the vaccine	**YES**	**NO**
5. Are you allergic to latex?		
6. Is this the first time you are receiving the vaccine?		

Please be sure to complete all of the information on the front side of this form. Thank you.

*Providers are required by law to report your immunizations to the Massachusetts Immunization Information System (MIIS) (M.G.L c.111, Section 24M). For more information, please visit the MIIS website at www.mass.gov/dph/miis, or contact the Massachusetts Immunization Program directly at 617-983-6800 or 888-658-2850.

☐ *I wish to opt out of the MIIS, which means my vaccination record will not be available to my PCP or other healthcare provider. I understand I need to complete an opt-out form. Please call the Health Department at 781-316-3170 to request an opt-out form or go to* http://www.mass.gov/eohhs/docs/dph/cdc/immunization/miis-objection-form.pdf to download the form. Opt out forms will also be available at each clinic.