Childhood 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

Information about the person to receive vaccine (please print): *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 Number: (if available)
Medicare Number:	Is Medicare Primary? Yes No	Is Subscriber Retired? Yes No

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		

Influenza Vaccine Screening Questionnaire

1. Does your child have a serious allergy to eggs? Yes No
2. Has your child ever had a serious reaction to a previous dose of flu vaccine? Yes No
3. Has your child ever had Guillain-Barre Syndrome (a temporary severe muscle weakness) Yes No
   within 6 weeks after receiving a flu vaccine?
4. Does your child have any chronic health conditions? (asthma, diabetes, lung disease etc.) Yes No

List other serious allergies: _____

***I GIVE CONSENT for my child named above to get vaccinated with this vaccine and* permission for my insurance company to be billed.**

X _____ **Date:** _____

(Signature of patient, parent or legal guardian

Provider Name: __Hull Board of Health_____ MDPH Provider PIN#:10729_____

Provider Address: 253 Atlantic Ave, Hull, MA 02045___

2019-2020 Childhood Vaccine Insurance Information Form

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)
- ☐ Does not have health insurance
- ☐ Is American Indian (Native American) or Alaska Native

Is not VFC-eligible:

- ☐ Has health insurance and is not American Indian (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 (Circle)	Preserv Free	Injection Route (Circle)	Injection Site (Circle)	Date On VIS	Date VIS Given
	IIV4	Sanofi			0.5	no	yes	IM	R Arm L Arm	8/15/19	

IIV4 = Inactivated influenza vaccine, quadrivalent

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