2020-2021 Flu 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 insurance subscriber/policy holder, 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		

I give permission for my insurance company to be billed.

X _____ Date: _____

(Signature of patient, parent or legal guardian)

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***Place Photo Copy of All Insurance Cards Here:**

Provider Name: TOWN OF WALPOLE HEALTH DEPARTMENT MDPH Provider PIN#: 11720

Provider Address: 135 SCHOOL STREET WALPOLE, MA 02081

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For children 18 years of age and younger:

	YES	NO
1. Reviewed and signed attached COVID-19 questionnaire?		
2. Do you (or your child) feel sick today?		
3. Do you (or your child) have allergies to latex, medications, food or vaccines (examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)?		
4. Have you (or your child) ever had a serious reaction after receiving the flu vaccine, including feeling faint or dizzy?		
5. Have you (or your child) ever had Guillain-Barre` Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		

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	State Supplied (Circle)	Free*	Lot No	Exp Date	Dose (mL)	Injection Route (Circle)	Injection Site (Circle)	Date On VIS	Date Given
	IIV4	Sanofi Pasteur	Yes No	Yes No			0.5	IM	R Arm L Arm R Leg L Leg	8/15/2019	10/4/2020
	Fluzone High Dose (HD-IIV4)	Sanofi Pasteur	No	Yes	UJ468AB	06/30/2021	0.7	IM	R Arm L Arm	8/15/2019	10/4/2020

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COVID-19 QUESTIONNAIRE

TEMPERATURE:

If you have a temperature of **100.0** or greater:

Please DO NOT come to the clinic

SYMPTOM CHECKER:

Do you have / a:	**YES**	**NO**
Cough (not related to a chronic condition)		
Chills (with or without a fever)		
Runny nose (not related to seasonal allergies)		
Headache		
Sore Throat		
Muscles Aches		
Shortness of Breath		
New loss of taste or smell		

EXPOSURE:

	YES	**NO**
Within the last 24 hours, have you experienced any of the above symptoms?		
Within the last 14 days, have you had contact with someone who has tested positive or is under review for COVID-19?		
Have you tested positive for an active COVID-19 infection in the past 10 days?		
Within the past 14 days, has a public health or medical professional told you to self-monitor, self-isolate or self-quarantine because of concerns about COVID-19 infection?		

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SIGNATURE: _____ DATE: _____

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