2013-2014 Influenza Vaccine Consent and Screening 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)

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		

I give permission for my insurance company to be billed.

X _____ Date: _____

(Signature of patient, parent or legal guardian)

I GIVE CONSENT *for me / my child named at the top of this form to get vaccinated with this vaccine.*

___ Injectable only ____ Nasal mist only ____ Either injectable or nasal mist

X _____ Date: _____

(Signature of patient, parent or legal guardian)

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For Clinic/Office Use Only:

Date vax given:	Vax Type	Vax Manufacturer	Exp. Date/ Lot No	Dose	State Suppl-ied	Preserv Free	Injection Route (Circle)	Injection Site (Circle)	Date On VIS	Date VIS given
					Yes	Yes No	IM	R Arm L Arm R Leg L Leg	07/26/13	
	LAIV4	Medimmune		0.2 ml	Yes	N/A	Intranasal	N/A	07/26/13	

For children 18 years of age and younger:

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

Clinic Site Name: Berkshire County Boards of Health Association MDPH Provider PIN#: 11340

Clinic Address: 1 Fenn St, Suite 302, Pittsfield, MA 01201

Signature of Vaccine Administrator: _____ *Date:* _____

Screening for *Injectable (Flu Shot) or Nasal Spray* Vaccines

Information to determine if you or your child should receive the 2013-2014 flu vaccine.

	NO	YES
1. Do you or your child have a problem eating eggs?		
2. Do you or your child have an allergy to gentamicin, neomycin, polymixin or gelatin?		
3. Have you or your child ever had a serious reaction to a flu vaccine in the past?		
4. Have you or your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		

There are 2 kinds of flu vaccine available. Your answers to the following questions will help us decide if you or your child is able to receive the nasal spray (live) vaccine.

	NO	YES
1. Have you or your child received any vaccine (not just flu) within the past 30 days? Vaccine: _____ *Date given:* month ____ day ____ year____		
2. Do you or your child have asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?		
3. If your child is younger than 5 years old, has a healthcare provider told you that your child had wheezing or asthma within the last 12 months?		
4. Do you or your child take aspirin or aspirin-containing medicine every day?		
5. Do you or your child have a weak immune system (from HIV, cancer, or medicines such as steroids or those used to treat cancer)?		
6. Are you or your child pregnant?		
7. Do you or your child have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?		

Permission to Share Information: Complete only if you consented to have your child receive flu vaccine. This information will be shared to ensure that your child is appropriately vaccinated. You may refuse to sign this authorization to share information. Refusal to sign will not affect your child's ability to obtain vaccine

I, _____, give permission to the individual and/or entity that administered the 2013 -
(Print your name)

2014 influenza vaccine to my child _____ to share copies of the 2013 – 2014 flu
(Print child's full name)

vaccine consent form and vaccination record with my child's school and health care provider named below, as well as with the Massachusetts Department of Public Health and the local board of health in my community. I also give permission for each of these entities to share the 2013-2014 seasonal influenza consent form and vaccination record with each other.

My child's health care provider:

Name:_____

Address: _____

_____

My child's school:

Name:_____

City or town: _____

- This health information is disclosed at my request and to ensure my child is appropriately vaccinated.
- This permission expires at the end of the 2013 – 2014 school year.
- If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information received may no longer be protected by federal privacy regulations. State privacy regulations cover information received by the MA Department of Public Health and local boards of health.
- I understand that I may inspect or copy the protected health information to be disclosed under this permission to share.
- Permission to shre is compliant with HIPAA and FERPA requirements.
- Finally, I understand that I may withdraw this permission in writing at any time by sending written notification to:

_____
(School/institution/individuals handling withdrawals must insert name and address)

However, if I withdraw permission at a later date, any vaccine consent form and vaccine record already shared will not be covered by the withdrawal.

_____ _____
Signature of Parent or Guardian Printed name of Parent or Guardian

Address:_____ Date signed:____/____/____