

## 2016 - 2017 Registration & Insurance Information Form for Vaccination

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**

Child's Name: (Last, First, MI)*			Date of birth: * ____ / ____ / ____ Month Day Year			Age*	Sex: (Circle)* Male Female	
Street Address:*								
City:*			State: *		Zip:*		Parent/Guardian Daytime Phone:*( )	
School Name			Homeroom/ Homeroom Teacher			Grade		

**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 Employed? 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							

<p><b>For Everyone, please circle response:</b></p> <p>1. Is the person receiving the vaccine sick today? <b>Y N</b></p> <p>2. Does the person to be vaccinated have an allergy to eggs ? <b>Y N</b></p> <p>3. Has the person to be vaccinated ever had Guillain-Barré syndrome? <b>Y N</b></p> <p>4. Has the person to be vaccinated ever had a serious reaction to the flu vaccine? <b>Y N</b></p>	<p><b>For children 18 years of age and younger: please check the box next to any statements that are applicable:</b></p> <p>Is Vaccine for Children (VFC) Program eligible:</p> <p><input type="checkbox"/> Is enrolled in Medicaid (includes MassHealth and HMOs etc. if enrolled through Medicaid)</p> <p><input type="checkbox"/> Does not have health insurance</p> <p><input type="checkbox"/> Is American Indian (Native American) or Alaska Native</p> <p>Is not VFC-eligible:</p> <p><input type="checkbox"/> Has health insurance and is not American Indian (Native American) or Alaska Native</p>
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**I give permission for my insurance company to be billed. I acknowledge that I (or my child) will receive the Flu Vaccine and I have received the Vaccine Information Sheet, dated August 7, 2015.**

X \_\_\_\_\_ Date: \_\_\_\_\_  
(Signature of patient, parent or legal guardian)

**For Clinic/Office Use Only:**

Date of Service	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
								IM	R Arm L Arm R Leg L Leg	8/7/15	

Provider Name: Bedford Board of Health MDPH Provider PIN#: 10119

Provider Address: Town of Bedford- BOH 12 Mudge Way, Bedford, MA, 01730

Signature of Vaccine Administrator: \_\_\_\_\_ Date: \_\_\_\_\_