# 2021-2022 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) |
|---|---|---|

**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 |

**To help us determine if your child is eligible to receive vaccines from the Vaccines for Children Program, please check one of the boxes below.** Your child will receive flu vaccine whether or not they are eligible.

- ☐ My child is enrolled in Medicaid (includes MassHealth and HMOs, etc., if enrolled through Medicaid)
- ☐ My child does not have health insurance
- ☐ My child is American Indian (Native American) or Alaska Native
- ☐ My child has health insurance and is not American Indian (Native American) or Alaska Native

**I give permission for my insurance company to be billed and my child to be immunized.**

X _____ Date: _____

(Signature of patient, parent or legal guardian)

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**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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| / /20 | | S/P | | | 0.5 | Yes | No | IM | R Arm L Arm R Leg L Leg | 8/7/15 | / /20 |
| / /20 | Quadrivalent Prefilled syringes | S/P | | | 0.25 | Yes | Yes | IM | R Leg L Leg | 8/7/15 | / /20 |

Provider: Town of Norton Health Department, 70 E. Main St, Norton, MA 02766 MDPH Provider PIN#: 12209

# 2021-2022 Insurance Information Form

The Massachusetts Immunization Information System (MIIS), also called an immunization registry, is a confidential, web-based system that collects and stores vaccination (shot) records for Massachusetts residents of all ages. Your child's shot information is being entered into MIIS. ***By law, immunization information for all patients must be reported to the MIIS.*** You can choose to restrict who may see you or your' child's shot information in the MIIS at any time. Please ask the healthcare provider for further information or refer to http://www.mass.gov/eohhs/gov/departments/dph/programs/id/immunization/miis.

Do you wish to share your child's ***immunization information*** with other healthcare providers: ◯ **Yes** ◯ **No**

*If "No" then an Objection Form must be completed by the parent/guardian. Obtain from school or NortonHealth Dept.*

**Child's Physician: _____**

Please mark "Yes", "No" or "Unknown' to questions below:

| | Yes | No | Unknown |
|---|---|---|---|
| 1. Are you sick today? (Fever >101F, severe malaise) | ◯ | ◯ | ◯ |
| 2. Does your child have an allergy to thimerosal, gentamicin, neomycin, polymixin, gelatin or latex? | ◯ | ◯ | ◯ |
| 3. Is this your child's first flu shot? | ◯ | ◯ | ◯ |
| 4. Has your child ever had a serious reaction to flu shot in the past? | ◯ | ◯ | ◯ |
| 5. Has your child ever had Guillain-Barre Syndrome (a temporary severe muscle weakness) within 6 weeks after receiving flu shot?<br><br>** If yes, **DO NOT** administer the vaccine and have individual consult with Primary Care Physician. ** | ◯ | ◯ | ◯ |
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