

2020-2021 Flu Vaccine Form



Information about the person to receive vaccine (please print): *Required Fields

Name*: (Last, First, MI)	Date of Birth*: ____/____/____	Age*:	Sex*: (Circle) Male Female
Street Address*:			
City*:	State*:	Zip Code*:	Phone*: ()

Name of Insurance Company: _____

For children 18 years of age and younger:

- ☐ Is enrolled in Medicaid (includes Mass Health 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.

For Clinical/Office Use Only:

Date of Service	Vac Type	Vac Manufacturer	Ex. Date/Lot NO.	Dose (mL)	State Supplied	Preserv. Free	Injection Route (Circle)	Injection Site (Circle)	Date on VIS	Date VIS Given
	IIV4	GSK	6/30/21	0.5	No	Yes	IM	R Arm R Leg L Arm L Leg	2019	

Provider Name: Salmon VNA & Hospice MDPH Provider Pin #: 14989

Provider Address: 37 Birch Street, Milford, MA 01757 NPI#: 11 24386255

Signature of Vaccine Administrator: _____ Date: _____

2020-2021 FLU Immunization Screening Questionnaire

- Have you ever had an anaphylactic reaction or other **serious** reaction to previous flu vaccines? ☐ Yes ☐ No
- Are you allergic to eggs or egg protein? ☐ Yes ☐ No
- Do you currently have an illness with a fever? ☐ Yes ☐ No
- Are you pregnant or suspect that you may be pregnant? ☐ Yes ☐ No
- Have you ever been paralyzed with Guillain-Barre Syndrome? ☐ Yes ☐ No
- Are you allergic to thimerosal (merthiolate), found in some contact lens solutions? ☐ Yes ☐ No
- Are you allergic to dry, natural latex rubber? ☐ Yes ☐ No