

**2020- 2021 INFLUENZA VACCINE CONSENT AND SCREENING FORM**  
**Injectable (Flu Shot)**

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

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 CONSENT** for me / my child named at the top of this form to get vaccinated with this vaccine. I have read or had explained to me the 2020-2021 Vaccine Information Statement for the influenza vaccine and understand the risks and benefits.

\_\_\_ Injectable only

**I give consent for my insurance company to be billed** if insurance information is entered above.

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

**For children 18 years of age and younger:**

**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

\*\*\*\*\*  
**For Clinic/Office Use Only:**

Date vax given:	Vax Type	Vax Manufacturer	Exp. Date/ Lot No	Dose	State Supplied	Preserv Free	Injection Route (Circle)	Injection Site (Circle)	Date On VIS	Date VIS given
					Yes No	Yes No	IM	R Arm L Arm R Leg L Leg	08/15/19	

Clinic Site Name: Berkshire County Boards of Health Association

MDPH Provider PIN#: 15100

Clinic Address: 1 Fenn St, Suite 201, Pittsfield, MA 01201

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

## Screening for *Injectable (Flu Shot)*

Answering these questions will help us to know which type of flu vaccine your child should get and whether your child should get 0, 1 or 2 doses of flu vaccine.

**If the person receiving vaccine is not a child, skip to section 2.**

### Section 1: Information to determine if your child should receive 0, 1 or 2 doses of flu vaccine

If your child is 9 years old or older, go to Section 2 below.

If your child is 8 years old or younger, answer the other questions in this box.

1. Did your child receive 1 or more doses between July 1, 2019 and June 30, 2020?  Yes  No

2. Has your child received flu vaccine this flu season (since July 1, 2020)?  No **If no, go to Section 2**  Yes

If yes, please tell us the number of doses and dates of vaccination.  1 dose  2 doses

**Dose 1:** Date received: month \_\_\_\_ day \_\_\_\_ 2019 **Dose 2:** Date received: month \_\_\_\_ day \_\_\_\_ 2020

### Section 2: Information to determine whether the person receiving vaccine should receive the 2020-2021 flu vaccine.

A. Please check YES or NO for each question.

	NO	YES
1. Is the person receiving vaccine sick today?		
2. Does the person receiving vaccine have a problem eating eggs?		
3. Has the person had an anaphylactic reaction to latex?		
4. Does the person receiving the vaccine have an allergy to gentamicin, neomycin, polymixin or gelatin?		
5. Has the person receiving vaccine ever had a serious reaction to a flu vaccine in the past?		
6. Has the person receiving vaccine ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		

**MIIS Policy:** Massachusetts law (M.G.L. c. 111, Section 24M) requires providers to report immunization information to computerized immunization registry known as the Massachusetts Immunization Information System (MIIS). The MIIS stores immunization records for you and your healthcare provider and can help prevent outbreaks of disease like measles and the flu. All information in the MIIS is kept secure and confidential. The MIIS allows information to be shared with health care providers, school nurses, local boards of health, and state agencies concerned with immunization. You have the right to object to the sharing of your immunization information across providers in the MIIS. For more information, please ask your healthcare provider, visit the MIIS website at [www.mass.gov/dph/miis](http://www.mass.gov/dph/miis) or contact the Massachusetts Immunization Program directly at 617-983-6800 or 888-658-2850.