2020- 2021 INFLUENZA VACCINE CONSENT AND SCREENING FORM
Injectable (Flu Shot) or Nasal Spray Flu Vaccine

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 ____ Nasal mist only ____ Either injectable or nasal mist

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)

If you would like us to share a copy of this vaccination with your provider, employer or school, please list the names and towns below:

_____

_____

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 or contact the Massachusetts Immunization Program directly at 617-983-6800 or 888-658-2850.

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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
				0.5 ml	Yes No	Yes No	IM	R Arm L Arm R Leg L Leg	08/15/19	
	LAIV4			0.2 ml	Yes No	N/A	Intranasal	N/A	08/15/19	

Clinic Site Name: Fairview Hospital Public Health Clinic MDPH Provider PIN#: 15024

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

Signature of Vaccine Administrator: _____ *Date:* _____

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

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

To help us determine if your child (18 years of age and younger) 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

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?		

B. There are several kinds of flu vaccine available. Your answers to the following questions will help us decide whether the nasal spray (live vaccine) is appropriate. **If you are 50 or older you may skip this section.**

	NO	YES
1. Has the person receiving vaccine received any vaccine (not just flu) within the past 30 days? Vaccine: _____ *Date given:* month ____ day ____ year____		
2. Does the person receiving vaccine have asthma?		
3. Does the person receiving vaccine have diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?		
3. If the person receiving vaccine 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. Does the person receiving vaccine take aspirin or aspirin-containing medicine every day?		
5. Is the person receiving vaccine receiving antiviral medications?		
6. Does the person receiving vaccine have a weak immune system (from HIV, cancer, or medicines such as steroids or those used to treat cancer)?		
7. Is the person receiving vaccine pregnant?		
8. Does the person receiving vaccine have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?		