Town of

Longmeadow, Massachusetts

20 Williams Street, Longmeadow, MA 01106

phone: 413-565-4140 fax:*413-565-4371*

BEVERLY S. HIRSCHHORN, CHO, MPH
Health Director

BOARD OF HEALTH
ROBERT BAEVSKY, M.D.
BARRY IZENSTEIN, M.D.
ROBERT RAPPAPORT, D.M.D.
RICHARD STEINGART, M.D.
MARIPAT TOYE, R.N., M.S.

ASSOCIATE MEMBER
Anastasios Angelides, M.D.

____ ________________

Print Name (last name, first name) Date of Birth

SELF-SCREENING TOOL FOR SEASONAL INFLUENZA VACCINE

(Injectable version, adult recipient)

If you respond "yes" to any of these questions, kindly inform the Nurse who will be administering the vaccine.

1. Are you moderately ill today (e.g. Do you have a cough or fever)? Yes ____ No ____

2. Are you pregnant? Yes ____ No ____ Not Applicable _____

   If yes, please provide the month of the pregnancy _________

3. Have you had an allergic reaction to a previous dose of Flu Vaccine? Yes ____ No ____

   Note: Redness and minor discomfort at the vaccine site that lasts only a few days is not an allergic reaction.

4. Have you ever had an allergic reaction to:

   - Eggs or egg products? Yes ____ No ____
   - Other vaccine components (e.g. gelatin, vaccine preservatives)? Yes ____ No ____
   - Latex? Yes ____ No ____

5. Have you ever had Guillain-Barre Syndrome (an illness characterized by sudden muscle weakness and loss of sensation of the extremities)? Yes ____ No ____

____ _______________________

Patient Signature Date

____ _______________________

Signature, Vaccine Administrator Date

Adult Vaccine Documentation Record

SIGNATURE OF THE PERSON TO RECEIVE A VACCINE (OR THAT PERSON'S GUARDIAN) FROM THE LONGMEADOW BOARD OF HEALTH AFFIRMING:

- **RECEIPT OF THE VACCINE INFORMATION STATEMENT (VIS) FOR THE VACCINE TO BE ADMINISTERED;**
- **CONSENT TO THE LONGMEADOW BOARD OF HEALTH TO ADMINISTER THE VACCINE INDICATED ON THE VACCINE INFORMATION STATEMENT (VIS).**
- **PERMISSION FOR THE LONGMEADOW BOARD OF HEALTH OR THE MASS. DEPT. OF PUBLIC HEALTH TO SUBMIT A CLAIM TO MEDICARE B OR TO ANOTHER PRIVATE OR PUBLIC INSURER FOR REIMBURSEMENT FOR THE COST OF THE VACCINE AND ITS ADMINISTRATION UNLESS THE PATIENT RENDERS PAYMENT OF A FEE TO COVER SUCH COSTS OR THE BOARD WAIVES PAYMENT.**
- **CONSENT TO RECORD A RECORD OF THIS IMMUNIZATION ON THE MASS. DEPT. OF PUBLIC HEALTH VACCINE REGISTRY AVAILABLE EXCLUSIVELY TO REGISTERED MEDICAL PROVIDERS.**

Signature of person to receive vaccine or that person's guardian.

_______________________________ **Date:** _______________

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

Name (Last, First, Middle):	Date of Birth:	Age:
Street address:		
City:	State:	Zip:
Email:	Phone #	

For Clinic/Office Use

Vaccine name: _______________ Date vaccine administered: _______________

Route/injection site[2]: IM RA / LA Date VIS given: _________ Date on VIS: 8/15/2019

Vaccine manufacturer: SANOFI PASTEUR Vaccine lot number: _______________

Name/ Title of vaccine administrator: _______________ Initials: _________

Clinic/office address: 231 Maple Road, Greenwood Adult Center, Longmeadow, MA 01106

The Massachusetts Immunization Program does **not** require use of this form. However, it does contain all the federally-required documentation relating to immunization and may be used for your clinic records.

Site given: RA = right arm, LA = left arm, RL = right leg, LL = left leg. Route given: SC = subcutaneously, IM = intramuscularly.

2020-2021 Flu Insurance Form (Adults)

*Required Fields: **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:* Longmeadow	State: * MA	Zip:* 01106	Phone:* (413)

*Required Fields:

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 (if applicable)*	Is Medicare Primary? Yes No	Is Subscriber Retired? Yes No

If person getting vaccinated is not the insurance subscriber/policy holder, 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:* Longmeadow	State:* MA	Zip: * 01106	Phone:* (413)
Patient Relationship to Subscriber: (Circle)*	Spouse	Child	Other

I give permission for my insurance company to be billed. (signature/dating of forms is required)

X ____ Date:: __________

(Signature of patient or legal guardian)

****

For Clinic/Office Use Only:

Date of Service	Vax Type	Vaccine Mfgr	State Supplied	Preserv Free*	Lot No.	Exp Date	Dose (mL)	Injection Route	Injection Site (Circle)	Date On VIS	Date VIS Given
		Sanofi Pasteur	No	no			0.5ml	IM	R Arm L Arm	8/15/2019	

Signature of Vaccine Administrator: ____________________ Initials:______ Date: ____________________

Provider Name: Longmeadow Board of Health MDPH Provider PIN#: 15016

Provider Address: 20 Williams Street, Longmeadow, MA 01106