VISITING NURSE ASSOCIATION OF CAPE COD
Member Cape Cod Healthcare

Ins No Ins

Flu Vaccine Immunization Record CHILD

PLEASE PRINT

PLEASE PRINT NAME EXACTLY AS IT APPEARS ON INSURANCE CARD

	(Last)	(First)	(MI)	Birth date:	Sex:
Child's Name:				/ /	Male Female
St address:				age:	Phone:
City:				State:	Zip:
Mailing address if diff:					
City:				State:	Zip:

Contact info if diff than above:

Insurance information: **I do not have insurance**

ACCEPTED INSURANCES: Aetna, BC/BS of MA, BMC, Fallon, HP, Masshelath, Tufts, Unicare/Comm Indemnity

Insurance Name: _____ Is subscriber employed? Yes or No

Policy number: _____ **Suffix:** _____ **Group #** _____

***** MUST include all letters at beginning/end of policy ID number**

Subscriber DOB: ___/___/___ Subscriber Sex: F M

Subscriber Name: _____

Patient relationship to Subscriber: Please Circle Spouse Child Self

My child MAY MAY NOT have flumist (nasal spray) (ages 2-19)

Is your child allergic to eggs	NO	YES	Is your child allergic to Thimerosal (mercury)	NO	YES
Is your child ill today	NO	YES	Has your child had the Flu Shot before	NO	YES
Is your child allergic to latex	NO	YES	Has your child ever had Guillian Barre Syndrome	NO	YES

☐ Is American Indian (Native American) or Alaska Native

☐ Has health inusrance and is not American Indian (Native American) or Alaska Native

☐ Is enrolled in Medicaid (includes MassHealth and HMO's etc if enrolled through Medicaid

****FOR FLUMIST ONLY:**	Does your child live with someone who is immune suppressed			NO	YES
Does your child have diabetes; or chronic illness:	NO	YES	Is your child pregnant:	NO	YES
Does your child use a rescue inhaler :	NO	YES			

***** If you answered yes to any of the flumist only questions, your child will receive the IM dose of vaccine**

By signing below I am giving my permission for my Insurance to be billed and confirm that I have been given a copy and have read or have had explained to me the information on the flu vaccine information sheet. *8/7/2015*

_____ _____

Signature of person to receive vaccine or that persons guardian **Date**

DO NOT WRITE BELOW THIS LINE

Admin site: RD LD Nasal Nurses name: _____ Date administered: _____

Vaccine Name: _____ Vaccine Manufacturer: _____ Lot # _____

Provider name: VNA of Cape Cod, Inc

Clinic/office address: 255 Independence Drive, Hyannis MA 02601 MDPH Provider PIN # TRURO

name/location clinic

Your signature above authorizes the release of protected health information pertaining to treatment, payment and operations necessary to this billing process, physicians, medical facilities, contracting provider, and community agencies involved in your care, quality review activities (internal and external, including regulatory and accrediting organizations), and release of outcome information to the state and center for Medicare and Medicaid Services, and Joint commission on Accreditation of Health Care Organizations.