VISITING NURSE ASSOCIATION OF CAPE COD
An Affiliate of Cape Cod Healthcare

Ins **No Ins**

Flu Vaccine Immunization Record CHILD

PLEASE PRINT

please write name exactly as appears on Insurance Card

(Last)		(First)	(MI)	Birth date:	Sex: M F
Child's Name:				/ /	
St address:				age:	Phone:
City:				State:	Zip:
Mailing address if diff:					
City:				State:	Zip:
Parent's Name:				**Teacher:**	
Contact info if diff than above:					

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

BC/BS MA; Harvard Pilgrim;Aetna;Tufts;Fallon;BMC;NHP;Health New England;Unicare, MassHealth

Insurance Name: ______________________

Policy number: ______________ Group 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
			Has your child ever had Guillian Barre Syndrome	NO	YES

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.

7/2/2012

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

DO NOT WRITE BELOW THIS LINE

Admin site: RD LD Nasal Nurse initials: ________ Date vaccine administered: ________

Vaccine Name: ________ Vaccine Manufacturer: ________ Lot # ________

Name and title of vaccine administrator: VNA of Cape Cod, Inc ________

name/location of clinic

Clinic/office address: 255 Independence Drive, Hyannis MA 02601

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 relese of outcome information to the state and center for Medicare and Medicaid Services, and Joint commission on Accreditation of Health Care Organizations.