2023 - 2024 Flu Vaccination Registration Form and Consent

Information about the person to receive vaccine:

Name: (Last, First, MI)	Date of birth: / /	Age	Sex (Circle): Male Female

RACE: (Circle)

American Indian or Alaskan Native | Black or African American | Middle Eastern
North African | Hawaiian or Other Pacific Islander | White
Asian | Hispanic or Latino | Other

Street Address:			
City:	State:	Zip:	Phone:

Primary insurance information:

Name of Insurance Company:	Member ID Number:	Group ID Number:

Secondary insurance information:

Name of Insurance Company:	Member ID Number:	Group ID Number:

If person getting vaccinated is not the subscriber, please complete the following:

Subscriber's Name: (Last, First, MI)	Subscriber's Date of Birth: / /	Sex: (Circle) Male Female
Patient Relationship to Subscriber (Circle): Spouse Child Other		

All persons being vaccinated must answer the questions numbered 1 – 5:	**Circle Yes, No, or Don't Know**
1. Is the person to be vaccinated sick today?	YES NO DON'T KNOW
2. Does the person to be vaccinated have an allergy to an ingredient of the vaccine?	YES NO DON'T KNOW
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	YES NO DON'T KNOW
4. Has the person to be vaccinated ever had Guillain Barré syndrome?	YES NO DON'T KNOW
5. Has the person to be vaccinated ever felt dizzy or faint before, during, or after a shot?	YES NO DON'T KNOW

All persons being vaccinated may answer the questions numbered 6 – 17:	**Circle Yes or No**
6. Are you worried that now or in the future you will lose your housing?	YES NO
7. Are you worried that now or in the future you won't have enough food for you and your family?	YES NO
8. Are you worried that now or in the future any of your utilities such as electricity or gas may be shut off?	YES NO
9. Do you find it difficult to pay for the very basics like food, housing, medical care, and heating?	YES NO
10. Do you feel physically and emotionally safe in your home?	YES NO
11. Do problems getting childcare make it difficult for you to work?	YES NO
12. Do you have a primary care doctor?	YES NO
13. Do you have health insurance?	YES NO
14. Do you currently have access to the internet in your home?	YES NO
15. Do you put off going to the doctor because you don't have transportation?	YES NO
16. If for any reason you need help with day-to-day activities such as bathing, preparing meals, or shopping, do you have the help you need?	YES NO
17. If applicable, do you agree to receive a phone call regarding your responses to questions 6 - 17?	YES NO

PLEASE ALSO COMPLETE BACK OF FORM

Please Read: This form will be entered into the Massachusetts Immunization Information System (MIIS) as REQUIRED by M.G.L. Ch. 111 Section 24M. The MIIS is a confidential, computerized statewide tracking system. Immunization records may be shared with health care providers, school nurses, local boards of health and state agencies concerned with immunization. See objection form if you choose not to share immunization data.

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Provide your consent:

I agree that:

1. The information I provided is correct.
2. I have been provided the vaccine information statement(s) and/or the EUA Fact Sheet (typically for COVID19 vaccines) for Recipients and Caregivers which has information about the side effects, risks and benefits of the vaccine or vaccines I am registering for. I will be able to ask questions at the time I receive my immunization.
3. I understand and agree that certain vaccines may not be appropriate for certain populations or people with certain conditions or symptoms. Prior to receiving the vaccine, I have had the opportunity to consult with a healthcare provider. I attest that I have been advised of the risks of receiving the vaccine. I understand that I will have the opportunity to ask further questions of a clinician when I am at the vaccination site and will be able to refuse the vaccine if it is not appropriate for me.
4. If I have insurance that covers me and/or the person I am registering, I give permission for my insurance company to be billed.
5. I understand that as required by state law, all immunizations will be reported to the Department of Public Health Massachusetts Immunization Information System (MIIS). This information shall be treated as confidential medical information and shall be used only as allowed by law. I can access the MIIS factsheet for Parents and Patients, at www.mass.gov/dph/miis, for information on the MIIS and what to do if I object to data being shared with other providers in the MIIS.
6. I have the legal authority to, and do hereby give, consent for myself or for any other person I registered to be vaccinated under this program (and in the event I am registering for someone other than myself, references prior to this sentence to "I" refers to the patient).

I agree to Color's Terms of Service and acknowledge that I have received and had an opportunity to review the Notice of Privacy Practices.

X _____ Date: _____

(Signature of patient, parent or legal guardian)

For Clinical Staff only:

Date of Service	Vaccine Name	Vaccine Mfgr.	Lot Number	Exp. Date	Dose (ml)	Inject. Route	Injection Site	VIS Date	Date VIS Given	State Supplied	Preserv Free
		SANOFI				IM	R Arm L Arm	8/21/21		N	N

Provider Name: ____City of Fitchburg_____ MDPH Provider PIN#: __10499__

Provider Address: ___718 Main Street, Fitchburg, MA 01420_____

Signature of Vaccine Administrator: _____ Date: _____