



TOWN OF WESTMINSTER
11 SOUTH STREET
WESTMINSTER, MASSACHUSETTS 01473
(978) 874-7409 • Fax (978) 874-7460
BOARD OF HEALTH

Influenza Vaccination Record

Administered by: Westminister Board of Health at Public Health Flu Clinic

Full Name: _____

Date of Birth: _____

Influenza Vaccination Information

<u>Vaccine</u>	<u>Type</u>	<u>Date Administered</u>
2018 Seasonal Flu	IIV4	_____

Signature of Nurse or Health Agent _____

2018 Flu Insurance Information Form

The completion of this form is necessary for every vaccine recipient. If no insurance information is available, please fill out as much as possible using existing information.

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

Name: (Last, First, MI)*	Date of birth: *	Age*	Sex: (Circle)*
	<input type="text"/> / <input type="text"/> / <input type="text"/> <small>Month Day Year</small>		<input type="checkbox"/> Male <input type="checkbox"/> 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)
Medicare Number:	Is Medicare Primary? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is Subscriber Retired? <input type="checkbox"/> Yes <input type="checkbox"/> No

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)*
	<input type="text"/> / <input type="text"/> / <input type="text"/> <small>Month Day Year</small>	<input type="checkbox"/> Male <input type="checkbox"/> Female
Subscriber's Street Address: * (If different from address above)		
City:*	State:*	Zip: *
		()
Patient Relationship to Subscriber: (Circle)* Spouse Child Other		

I give permission for my insurance company to be billed.

X _____ Date: _____
 (Signature of patient, parent or legal guardian)

***Place Photo Copy of All Insurance Cards Here:**

Provider Name: Westminster Board of Health MDPH Provider PIN#: 14838

Provider Address: 11 South Street, Westminster, MA 01473