

# **REGIONAL H1N1 FLU CLINIC**



**Ages: 10 and up**

**Date: Wednesday, January 27**

**Time: 1:00pm to 7:00pm**

**Location: Osgood Landing (formerly Lucent/Western Electric); 1600 Osgood Street (Route 125), North Andover, MA**

**Please enter through the South Entrance (at the lights across from the new Gas Station/Dunkin Donuts) and enter the building at the Laser Craze entrance.**

**This clinic is free of charge. Registration form on next page.**

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

<b>Name: (Last, First, MI)*</b>		<b>DOB: (MM/DD/YY)*</b>	<b>Sex: (Circle)*</b> M F
<b>Address:*</b>			
<b>City:*</b>	<b>State:*</b>	<b>Zip:*</b>	<b>Phone:*</b> ( )

**INSURANCE INFORMATION:** *Include the prefix and suffix with the insurance ID number, if applicable.*

<b>Insurance Company:*</b>	<b>Member ID #:*</b>	<b>Group ID #:</b>
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If Patient is not the Subscriber, please complete the following:

<b>Subscriber's Name: (Last, First, MI)*</b>		<b>Subscriber's DOB:</b>	<b>Sex: (Circle)*</b> M F
<b>Subscriber's Address:*</b> <i>(If different from address above)</i>			
<b>City:*</b>	<b>State:*</b>	<b>Zip: *</b>	<b>Phone:*</b> ( )
<b>Patient Relationship to Subscriber:*</b> (Circle) Spouse Child Other			

**OTHER INSURANCE INFORMATION:** *Include the prefix and suffix with the insurance ID number, if applicable.*

<b>Insurance Company:*</b>	<b>Member ID #:*</b>	<b>Group ID #:</b>
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I give permission for my insurance company to be billed.

X \_\_\_\_\_  
(Signature of patient, parent or legal guardian)

Date: \_\_\_\_\_

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For Clinic/Office Use: Contact Person: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Vaccine Name: * (Circle)	Vaccine Manufacturer:	Vaccine Lot Number:	Date Vaccine Administered:*	Vaccine Type: * (Circle)	Injection Site: * (Circle)	Injection Route: * (Circle)
H1N1 Seasonal Influenza			(MM/DD/YY)	Dose #1 Dose #2	Right Arm Left Arm Right Leg Left Leg	Intramuscular Intranasal

Clinic Site Name: \_\_\_\_\_ Site PIN# : \_\_\_\_\_

Clinic Address: \_\_\_\_\_ Vaccine Administrator: \_\_\_\_\_

Date Vaccine Information Statement (VIS) given: \_\_\_\_\_ Date on VIS: \_\_\_\_\_

Signature of Vaccine Administrator: \_\_\_\_\_ Date: \_\_\_\_\_