

*NATICK BOARD OF HEALTH*  
**H1N1 FLU VACCINE  
CLINIC**

**Saturday, January 16, 2010**

**10:00am – 3:00pm**

**Kennedy Middle School Cafeteria  
1 Philip J Lucier Drive (off Mill St.)**

**This Clinic is open to ALL Natick Residents  
ages 2 years and older**

All children under 18 yrs must be accompanied by parents/guardians

Injectable and nasal vaccine available

*(There will be no injectable Thimerosal-free vaccine available at this Clinic)*

**For more information, call the Board of Health  
508-647-6460**

***Please complete form on back  
and bring to Clinic with Insurance Card***

## 2009-2010 Vaccine Administration Record

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> (If different from address above)			
<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 and to be vaccinated.

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

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

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For Clinic/Office Use:    Contact Person: Leila Mercer      Phone Number: 508-647-6460

Vaccine Name:*( Circle)	Vaccine Manufacturer:	Vaccine Lot Number:	Date Vaccine Administered:*	Vaccine Type:*( Circle)	Injection Site: *( Circle)	Injection Route:*( Circle)
H1N1	Medimmune Novartis SanofiPasteur	5008__ P 104041P1 UP ___ AA	01/04/10	Dose #1  Dose #2	Right Arm Left Arm Right Leg Left Leg	Intramuscular Intranasal

Clinic Site Name: Natick Health Department      Site PIN# : 11202

Clinic Address: 13 East Central St., Natick MA 01760      Vaccine Administrator: \_\_\_\_\_

Date Vaccine Information Statement (VIS) given: 01/04/10      Date on VIS: 10/02/09

Signature of Vaccine Administrator: Signature on file/      Date: 01/04/10