November 16, 2018

Dear Parents/Guardians:

The Sharon School Department and Sharon Board of Health are collaborating with the middle and high schools to administer flu shots. The Massachusetts Department of Public Health provided the *quadrivalent influenza vaccine* for children ≤ 18 years of age. This will protect against influenza strains expected to circulate. The CDC is not recommending nasal administration of the vaccine, so it is unavailable.

**Sharon High School** will administer flu shots during **Eagle Block** on **Wednesday, November 28, 2018**. There is no cost to you for this vaccine, and the following related materials are included with this letter:

- a consent form for administration of the flu shot
- an insurance form that supports reimbursement of associated costs to the Sharon Board of Health
- an influenza vaccine information statement from the CDC (VIS)
- a fact sheet and objection form from the Massachusetts Immunization Information System (MIIS)

If you intend on having your child receive the flu vaccine at Sharon High School, the appropriate materials from the list above must be brought to Ms. Feldman by **Monday, November 26th**. Doing so will ensure that your child receives the vaccine during the planned administration. No student will be immunized without formal consent.

In the absence of receiving the flu vaccine at Sharon High School, students are encouraged to get the vaccine through their own health provider, at town-sponsored administrations, or through other means (e.g. CVS).

Please call if you have any questions about the vaccine or the flu shot administration. Consider visiting the CDC’s influenza website at [www.cdc.gov/flu/](http://www.cdc.gov/flu/) for further flu-related information. We look forward to helping keep your child healthy during the flu season!

Regards,

**Debbie Feldman, RN**  
Sharon High School  
781-784-1554 X8007

**Mary Alice Nathan, RN**  
Sharon Middle School  
781-784-1560 X6005

**Sheila Miller, RN**  
Sharon Public Health Dept.  
781-784-1500 X1141
**2018-2019 Injectable or Flumist Influenza Vaccine Consent and Screening Form for Children**

18 years old and under: Section 1: Information about the student to receive vaccine (please print):

<table>
<thead>
<tr>
<th>Student's Name: (Last, First, MI)</th>
<th>Date of birth:</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Month</td>
<td>Day</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex: (Circle)</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Street Address:</th>
<th>Student School &amp; Grade/School</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City:</th>
<th>State:</th>
<th>Zip:</th>
<th>Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td>(      )</td>
</tr>
</tbody>
</table>

**Insurance Information:** Include the whole member ID number and any letters that are part of that number MUST PROVIDE A COPY OF ALL YOUR CHILD’S INSURANCE CARDS (please staple to this form)

<table>
<thead>
<tr>
<th>Name of Insurance Company:*</th>
<th>Member ID Number:*</th>
<th>Group ID Number: (if available)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Secondary Insurance Company</th>
<th>Member ID Number:*</th>
<th>Group ID Number: (if available)</th>
</tr>
</thead>
</table>

**Please complete the following:**

<table>
<thead>
<tr>
<th>Subscriber's Name: (Last, First, MI)*</th>
<th>Subscriber's Date of Birth: *</th>
<th>Sex: (Circle)*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Month</td>
<td>Day</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subscriber's Street Address:* (If different from address above)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City:*</th>
<th>State:*</th>
<th>Zip:*</th>
<th>Phone:*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>(      )</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Relationship to Subscriber: (Circle)*</th>
<th>Spouse</th>
<th>Child</th>
<th>Other</th>
</tr>
</thead>
</table>

Massachusetts law (M.G.L. c. 111, Section 24M) requires providers to report immunization information to a computerized immunization registry known as the Massachusetts Immunization Information System (MIIS). The MIIS stores immunization records for you and your healthcare provider. All information in the MIIS is kept secure and confidential. The MIIS allows information to be shared with health care providers, school nurses, local boards of health, and state agencies concerned with immunization. You have the right to object to the sharing of your immunization information across providers in the MIIS. For more information, please ask the nurse giving you the shot or contact the MA Immunization Program directly at 617-983-6800 or 888-658-2850.

I have read the information (VIS for injectable influenza vaccine and Flumist) provided about the vaccine I am receiving today. I understand the risks and benefits of the vaccine and authorize the Westford BOH to both administer the vaccine as well as to bill my insurance company. I have been informed about the Massachusetts Immunization System (MIIS). I have received the VIS and the MIIS Fact Sheet for Parents and Patients. Finally, I understand that I may withdraw this permission in writing at any time by sending written notification to: Westford Health Department, 55 Main St, Westford, MA 01886

I DO _____ DO NOT ________ Give permission for my child's flu vaccine information to be entered into the MIIS

<table>
<thead>
<tr>
<th>Parent/Guardian Signature</th>
<th>Printed Parent/Guardian Name</th>
<th>Date</th>
</tr>
</thead>
</table>

I GIVE CONSENT for my child named at the top of this form to get vaccinated with Influenza vaccine and for my insurance company to be billed. (If this consent is not signed, dated and returned, my child will not be vaccinated.)

<table>
<thead>
<tr>
<th>(Signature of parent or legal guardian)</th>
<th>Date:</th>
</tr>
</thead>
</table>

**DEADLINE TO PRE-REGISTER in schools:** Wednesday, October 24, 2018

_in addition: form used at public flu clinics as well as, for schools 2018-2019_
For children 18 years of age and younger:

- Is enrolled in Medicaid (includes MassHealth and HMOs etc. if enrolled through Medicaid)
- Does not have health insurance
- Is American Indian (Native American) or Alaska Native
- Has health insurance and is not American Indian (Native American) or Alaska Native

Screening Questions: All 12 questions MUST be answered or your child will NOT be vaccinated!

1. Has your child ever received a flu shot or Flumist?  YES  NO  If YES which one __________
2. Is your child allergic to eggs or egg protein?  YES  NO  If YES cannot receive either vaccine
3. Is your child allergic to gentamicin, gelatin, or arginine?  YES  NO  If YES cannot receive Flumist
4. Has your child ever had Guillain-Barre syndrome?  YES  NO  If YES cannot receive either vaccine
5. Has your child ever had a life threatening reaction to flu vaccine?  YES  NO
6. Is there a chance that your child is pregnant?  YES  NO  If YES cannot receive Flumist
7. Is your child allergic to gentamicin, gelatin, or arginine?  YES  NO  If YES cannot receive Flumist
8. Has your child ever had Guillain-Barre syndrome?  YES  NO  If YES cannot receive either vaccine
9. Has your child ever had a life threatening reaction to flu vaccine?  YES  NO
10. Does your child have a weakened immune system? (ie. from cancer drugs, high dose steroids, HIV, etc.)  YES  NO  If YES cannot receive Flumist
11. Will your child be around a person who has a severely weakened immune system?  YES  NO  If YES cannot receive Flumist
12. Has your child ever had recurrent wheezing, a history of asthma or a condition requiring the use of an inhaler at any time in her or her life?  YES  NO  If YES cannot receive Flumist

List all of your child’s allergies:

__________________________

PLEASE Indicate which vaccine you wish your child to receive by circling your selection:

(YOU MUST CIRCLE A CHOICE OF VACCINE OR FLUMIST *SEE RESTRICTIONS ON FLUMIST)

I have a limited supply of Flumist so it will be given out on a first come first serve basis based on when you signed and submitted the consent form

CIRCLE ONE CHOICE: I would like my child to receive:

- FLULAVAL (Injection)
  Westford Academy, Stony Brook and Blanchard ONLY
- FLUMIST (Intranasal)

__________________________

Signature of parent or guardian

Date

If you sign your child up for this program and he/she receives the vaccine at another venue (ie. doctor’s office) after you’ve registered but before the clinic dates, please contact the health dept secretary at 978-692-5509 to have your child’s name removed from our list.

BELOW FOR CLINIC USE ONLY:

<table>
<thead>
<tr>
<th>Date given</th>
<th>Vax Type</th>
<th>Vax Manufacturer</th>
<th>Exp. Date/ Lot No</th>
<th>Dose</th>
<th>State Supplied</th>
<th>Preserv Free</th>
<th>Injection Route</th>
<th>Injection Site (Circle)</th>
<th>Date On VIS</th>
<th>Date VIS given</th>
</tr>
</thead>
<tbody>
<tr>
<td>QIV</td>
<td>FluLaval</td>
<td>GSK</td>
<td>0.5mL</td>
<td>Yes</td>
<td>Yes</td>
<td>IM</td>
<td>L Arm</td>
<td>R Arm</td>
<td>8/7/15</td>
<td></td>
</tr>
<tr>
<td>LAIV</td>
<td>Flumist</td>
<td>Astra Zeneca</td>
<td>0.2mL</td>
<td>Yes</td>
<td>Yes</td>
<td>Intranasal</td>
<td>NA</td>
<td>8/7/15</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Vaccine Administrators Signature:

Clinic Site Name: Westford Health Dept
Clinic Address: 55 Main St, Westford, MA 01886  MDPH Provider PIN#: 11994

Gail Johnson, BSN, RN  Public Health Nurse:  Date:
2018 - 2019 Flu & Pneumo Insurance Information Form  
Town of Sharon Health Department  
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*

<table>
<thead>
<tr>
<th>Name: (Last, First, MI)*</th>
<th>Date of birth: Month/Date/Year *</th>
<th>Age*</th>
<th>Sex (Check)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Male □</td>
<td>Female □</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street Address: *</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City:*</th>
<th>State:*</th>
<th>Zip:*</th>
<th>Phone:*</th>
</tr>
</thead>
</table>

**Insurance Information: Include the whole member ID number and any letters that are part of that number**

<table>
<thead>
<tr>
<th>Name of Insurance Company:*</th>
<th>Member ID Number:*</th>
<th>Group ID Number: (if available)</th>
</tr>
</thead>
</table>

**MEDICARE #**

<table>
<thead>
<tr>
<th>Is Medicare Primary?</th>
<th>Is Subscriber Retired?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes ○</td>
<td>Yes ○</td>
</tr>
<tr>
<td>No ○</td>
<td>No ○</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Subscriber's Name: (Last, First, MI)*</th>
<th>Subscribers Date of birth: Month/Date/year *</th>
<th>Sex (Check)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Male □</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subscriber Street Address: *</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City:*</th>
<th>State:*</th>
<th>Zip:*</th>
<th>Phone:*</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Patient Relationship to Subscriber: *</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Spouse</td>
</tr>
<tr>
<td></td>
<td>□ Child</td>
</tr>
<tr>
<td></td>
<td>□ Other</td>
</tr>
</tbody>
</table>

**I give permission to receive the vaccine and for my insurance company to be billed.**

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

*************************************************************************************************************************

For children 18 years of age and younger:

**Is Vaccine for Children (VFC) Program eligible:**

- [ ] Is enrolled in Medicaid (includes MassHealth and HMOs, etc., if enrolled through Medicaid)
- [ ] Does not have health insurance
- [ ] Is American Indian (Native American) or Alaska Native

Is not VFC-eligible:

- [ ] Has health insurance and is not American Indian (Native American) or Alaska Native

**For Clinic/Office Use Only:**

<table>
<thead>
<tr>
<th>Vax Type</th>
<th>Vax Manufacturer</th>
<th>Dose</th>
<th>Preserv Free</th>
<th>Injection Route</th>
<th>Injection Site (Circle)</th>
<th>State Supplied</th>
<th>Date VIS (8/07/15) &amp; Vaccine Given</th>
<th>Exp Date Lot #</th>
<th>Signatuer of Vaccine Administrator</th>
</tr>
</thead>
<tbody>
<tr>
<td>IIV4</td>
<td>Sanofi</td>
<td>.5ml</td>
<td>Yes</td>
<td>IM</td>
<td>R Arm Arm</td>
<td>Yes</td>
<td>6/30/19 u62608A</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Provider Name: **Sharon Health Department**  
Provider Address: 90 South Main Street, Sharon, MA 02067  
MDPH Provider PIN# 11537
Influenza (Flu) Vaccine
(Inactivated or Recombinant): 
What you need to know

1 Why get vaccinated?

Influenza (“flu”) is a contagious disease that spreads around the United States every year, usually between October and May.

Flu is caused by influenza viruses, and is spread mainly by coughing, sneezing, and close contact.

Anyone can get flu. Flu strikes suddenly and can last several days. Symptoms vary by age, but can include:
• fever/chills
• sore throat
• muscle aches
• fatigue
• cough
• headache
• runny or stuffy nose

Flu can also lead to pneumonia and blood infections, and cause diarrhea and seizures in children. If you have a medical condition, such as heart or lung disease, flu can make it worse.

Flu is more dangerous for some people. Infants and young children, people 65 years of age and older, pregnant women, and people with certain health conditions or a weakened immune system are at greatest risk.

Each year thousands of people in the United States die from flu, and many more are hospitalized.

Flu vaccine can:
• keep you from getting flu,
• make flu less severe if you do get it, and
• keep you from spreading flu to your family and other people.

There is no live flu virus in flu shots. They cannot cause the flu.

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against three or four viruses that are likely to cause disease in the upcoming flu season. But even when the vaccine doesn’t exactly match these viruses, it may still provide some protection.

Flu vaccine cannot prevent:
• flu that is caused by a virus not covered by the vaccine, or
• illnesses that look like flu but are not.

It takes about 2 weeks for protection to develop after vaccination, and protection lasts through the flu season.

2 Inactivated and recombinant flu vaccines

A dose of flu vaccine is recommended every flu season. Children 6 months through 8 years of age may need two doses during the same flu season. Everyone else needs only one dose each flu season.

Some inactivated flu vaccines contain a very small amount of a mercury-based preservative called thimerosal. Studies have not shown thimerosal in vaccines to be harmful, but flu vaccines that do not contain thimerosal are available.

3 Some people should not get this vaccine

Tell the person who is giving you the vaccine:
• If you have any severe, life-threatening allergies.
If you ever had a life-threatening allergic reaction after a dose of flu vaccine, or have a severe allergy to any part of this vaccine, you may be advised not to get vaccinated. Most, but not all, types of flu vaccine contain a small amount of egg protein.

• If you ever had Guillain-Barré Syndrome (also called GBS).
Some people with a history of GBS should not get this vaccine. This should be discussed with your doctor.

• If you are not feeling well.
It is usually okay to get flu vaccine when you have a mild illness, but you might be asked to come back when you feel better.
4 Risks of a vaccine reaction

With any medicine, including vaccines, there is a chance of reactions. These are usually mild and go away on their own, but serious reactions are also possible.

Most people who get a flu shot do not have any problems with it.

Minor problems following a flu shot include:
• soreness, redness, or swelling where the shot was given
• hoarseness
• sore, red or itchy eyes
• cough
• fever
• aches
• headache
• itching
• fatigue

If these problems occur, they usually begin soon after the shot and last 1 or 2 days.

More serious problems following a flu shot can include:
• There may be a small increased risk of Guillain-Barré Syndrome (GBS) after inactivated flu vaccine. This risk has been estimated at 1 or 2 additional cases per million people vaccinated. This is much lower than the risk of severe complications from flu, which can be prevented by flu vaccine.
• Young children who get the flu shot along with pneumococcal vaccine (PCV13) and/or DTaP vaccine at the same time might be slightly more likely to have a seizure caused by fever. Ask your doctor for more information. Tell your doctor if a child who is getting flu vaccine has ever had a seizure.

Problems that could happen after any injected vaccine:
• People sometimes faint after a medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting, and injuries caused by a fall. Tell your doctor if you feel dizzy, or have vision changes or ringing in the ears.
• Some people get severe pain in the shoulder and have difficulty moving the arm where a shot was given. This happens very rarely.
• Any medication can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at about 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination.

As with any medicine, there is a very remote chance of a vaccine causing a serious injury or death.

The safety of vaccines is always being monitored. For more information, visit: www.cdc.gov/vaccinesafety/

5 What if there is a serious reaction?

What should I look for?
• Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or unusual behavior.

Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?
• If you think it is a severe allergic reaction or other emergency that can’t wait, call 9-1-1 and get the person to the nearest hospital. Otherwise, call your doctor.
• Reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS web site at www.vaers.hhs.gov, or by calling 1-800-822-7967.

VAERS does not give medical advice.

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling 1-800-338-2382 or visiting the VICP website at www.hrsa.gov/vaccinecompensation. There is a time limit to file a claim for compensation.

7 How can I learn more?

• Ask your healthcare provider. He or she can give you the vaccine package insert or suggest other sources of information.
• Call your local or state health department.
• Contact the Centers for Disease Control and Prevention (CDC):
  - Call 1-800-232-4636 (1-800-CDC-INFO) or
  - Visit CDC’s website at www.cdc.gov/flu

Vaccine Information Statement
Inactivated Influenza Vaccine

08/07/2015
42 U.S.C. § 300aa-26
The Massachusetts Immunization Information System (MIIS) keeps track of all immunizations which doctors and health care providers give to patients in Massachusetts. The system has been created according to state law (M.G.L c. 111, Section 24M), and is operated by the Massachusetts Department of Public Health (MDPH). All information in the MIIS is kept confidential.

The law requires that immunizations be reported to the MDPH through the MIIS. It allows for the information to be shared among doctors and nurses providing your care, school nurses, local boards of health, and staff at state agencies involved with immunization (including the WIC Program). The MIIS enables a new health care provider to check what shots you or your child have received in the past from other providers. Your records will only be available to those involved in your care, who have a reason to know about them. You have the right to limit who else may see your or your child’s information in the MIIS. If you prefer that your or your child’s immunization history not be shared in this way, you need to Object to sharing your or your child’s immunization information. If you have changed your mind or if you change your mind in the future and decide to share the information with more healthcare providers, you will need to Withdraw your previous objection to sharing your or your child’s immunization information.

What it means to Object to the sharing of your or your child’s immunization information:
- Your or your child’s immunization history will not be seen by all healthcare providers in the MIIS.
- Your or your child’s immunization information will still be in the MIIS, but only the provider(s) who gives you shots and the Department of Public Health will be able to see it.
- Please note: you will need to keep track of your or your child’s immunization records in the event that you change doctors or get immunizations from other health care providers.
- How to Object to the sharing of your or your child’s immunization information:
  o Check the box next to “I OBJECT” on the other side of this form and complete the information requested.
  o Give the completed form to your healthcare provider, or send by fax or mail to the Department of Public Health at the contact information provided on the other side of this form.

What it means to Withdraw a previous objection to sharing your or your child’s immunization information:
- You have changed your mind and decide to share your or your child’s information with all of your or your child’s healthcare providers who are using the MIIS.
- Once the Withdrawal has been processed your records will be made available to individuals involved in your care, who have a reason to know about them.
- How to Withdraw a previous objection:
  o Check “I WITHDRAW MY PREVIOUS OBJECTION” on the other side of this form and complete the information requested.
  o Give the completed form to your healthcare provider or send by fax or mail to the Department of Public Health at the contact information provided on the other side of this form.
**SHARING YOUR IMMUNIZATION INFORMATION**

**Objection (or Withdrawal of Objection) Form**

**Name of Patient:** _________________________________________________________

I OBJECT to the sharing of information in the MIIS about me or my child. I understand that this will keep my or my child’s doctor or other health care provider from being able to check the MIIS for immunization information that comes from other health providers. I further understand that this objection will not prevent my child or me from receiving immunizations.

I WITHDRAW MY PREVIOUS OBJECTION to the sharing of immunization information in the MIIS about me or my child. I understand that by signing and submitting this form, the MIIS will be able to share immunization information with my or my child’s doctor(s) or other health care providers and other persons allowed by law to view this information.

**Patient’s Information** (this information is necessary to properly identify the patient):

<table>
<thead>
<tr>
<th>Name: __________________________________________</th>
<th>Date of Birth: __ / __ / ______</th>
<th>MI</th>
<th>MM / DD / YYYY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last ____________________________ First __________</td>
<td>Mother’s Maiden Name: __________________________</td>
<td>Gender: __________________</td>
<td></td>
</tr>
<tr>
<td>For child younger than 18 yrs of age</td>
<td>Address: __________________________________________</td>
<td>Phone#: (<strong><strong>)</strong></strong>____________</td>
<td></td>
</tr>
<tr>
<td>City: __________________________ State: __________________ Zip Code: _______________</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Parent/Guardian Information** (required if form is completed for a child younger than 18 years of age):

<table>
<thead>
<tr>
<th>Name: __________________________________________</th>
<th>Date of Birth: __ / __ / ______</th>
<th>MI</th>
<th>MM / DD / YYYY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last ____________________________ First __________</td>
<td>Relationship to Patient: __________________________</td>
<td>CHECK IF ADDRESS &amp; PHONE # ARE SAME AS PATIENT’S</td>
<td></td>
</tr>
<tr>
<td>Address: __________________________________________</td>
<td>Phone#: (<strong><strong>)</strong></strong>____________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City: __________________________ State: __________________ Zip Code: _______________</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Signature of Patient, or Parent/Guardian** (if child is younger than 18 years of age):

Signature: __________________________________________ Date: __________________

**Health Care Provider Use Only** – please enter your contact information, mail or fax a copy of the form to MDPH, and keep the original for the patient’s record:

☐ CHECK TO CONFIRM THE DATA SHARING STATUS WAS CHANGED IN THE MIIS FOR THE ABOVE PATIENT. If an objection, change the patient’s data sharing status to No. If a withdrawal, change patient’s data sharing status to Yes.

Staff Member’s Name: __________________________
Facility or Practice Name: __________________________
Vaccine PIN#: __________________________ Staff Phone#: (____)_________ ext: __________

Please submit this form by mail or fax to the Massachusetts Department of Public Health:

Mailing Address: Massachusetts Immunization Information System (MIIS)
Immunization Program
Massachusetts Department of Public Health
305 South Street
Jamaica Plain, MA 02130

Fax: 617-983-4301