Influenza Vaccine Registration Form

VACCINATION EVENT DATE: **LOCATION:**

SECTION I - PATIENT INFORMATION *(Please print)*

LAST NAME	**FIRST NAME, MIDDLE INITIAL**
DoD ID NUMBER	**DATE OF BIRTH *(YYYYMMDD)***
LOCAL CELL PHONE NUMBER	**SEX** ☐ Male ☐ Female

SECTION II - SPONSOR INFORMATION *(If sponsor information is in section 1, skip this section)*

SPONSOR LAST NAME	**SPONSOR FIRST NAME, MIDDLE INITIAL**
SPONSOR DoD ID NUMBER	**SPONSOR LOCAL CELL PHONE NUMBER**

IF YOU HAVE TRICARE ONLY, STOP HERE. YOU HAVE COMPLETED THE FORM.

SECTION III - CATEGORY OF PATIENT *(Sponsor info for eligible dependents)*

☐ UN Command ☐ KATUSA ☐ Selected Reserve ☐ Korean EEC or HCP

☐ GS or Contractor ☐ NAF ☐ Retiree (w/o TRICARE) ☐ Agency other than DoD/DoW

SECTION IV - OTHER HEALTH INSURANCE INFORMATION

NAME OF POLICY HOLDER (*Last, First, Middle Initial)*	
INSURANCE NAME *(UNC Foreign Military, input country)*	
INSURANCE ADDRESS & TELEPHONE NUMBER *(UNC Foreign Military, input local mailing address)*	
MEMBER ID NUMBER	**GROUP NUMBER**

SECTION V - ADDRESS

MAILING ADDRESS *(APO only. If no APO, complete DD Form 2870)*
EMAIL ADDRESS