Seasonal Influenza Vaccine for Parents/Adults 2016-2017

I understand that I am receiving services from _____ and payment must be made, **in full**, **at the time of service.** The charge for the flu vaccination is a total **of $**_____ for the vaccine AND the administration costs. I understand that _____ **will not file my insurance claim**. If requested, I will be provided with a billing statement for my records. No insurance or other discounts will be honored.

I have *read the important information contained in the Vaccine Information Sheet* about the vaccine and understand the possible risks and benefits of the vaccination. I agree to receive the vaccine.

PARENTS, please fill out the information below:

Age:_____

Do you or have you had:		
An Egg Allergy?	❑Yes	❑No
Are you receiving chronic aspirin or aspirin containing therapy?	❑Yes	❑No
An Immune system disorder?	❑Yes	❑No
AIDS, HIV, Cancer or Organ Transplant?	❑Yes	❑No
Asthma or Reactive Airway disease?	❑Yes	❑No
Disease of the lungs, chronic bronchitis, emphysema, or cystic fibrosis?	❑Yes	❑No
Kidney disease?	❑Yes	❑No
Are you pregnant or nursing?	❑Yes	❑No
An Allergic Reaction to Previous Vaccination?	❑Yes	❑No
A History of Guillain-Barre Syndrome GBS?	❑Yes	❑No
Heart disease, heart attack, or stroke?	❑Yes	❑No
Any vaccine in the last month or plan to have any in the next month?	❑Yes	❑No
Diabetes or other metabolic disease?	❑Yes	❑No
Does anyone living with you have a compromised immune system?	❑Yes	❑No
Are you in close contact with severely immunocompromized individuals requiring a protective environment, such as bone marrow transplant?	❑Yes	❑No
Are you taking any prescription medicines to prevent or treat flu?	❑Yes	❑No
Are you currently ill?	❑Yes	❑No

If you answered Yes to any of the questions, we **may NOT be able to** administer this vaccine to you. Pease check with your regular doctor to determine if Seasonal Flu Vaccine is right for you.

I have read and understood the above and have been given a copy for my records.

_____ _____

Name Date of Birth Parents Signature Date

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For Office Use:

_____

Lot # Administering Nurse/Medical Assistant Signature

Paid by ❑ Cash ❑ Credit Card ❑ Check, Check # _____ ***(Keep this form with the encounter forms in your batch and give a copy of this form along with a printed billing statement to the parent.)***