

You have elected to have flu shots for your child(ren) and/or other members of your family at the cost of **\$25 per injected flu vaccine or \$40 for the nasal flu mist. You are requesting these services at your own expense.** You will be responsible for payment at the time the flu vaccine is given and **you agree not to submit these charges to your insurance company.** I understand that I may obtain this vaccine from other providers if preferred. The amount we are charging for flu shots are merely our costs to perform these services as a convenience to you and your family. I understand I may obtain the vaccine through other venues.

I understand and agree to the charges listed above and will make payment prior to leaving the office today.

Parent Initials: _____ Date: _____

I request that my child receive the influenza vaccine today. I have read the information about the influenza vaccine/flu mist and have had a chance to ask and have my questions answered to my satisfaction regarding the vaccine and potential side effects. I understand the risks and benefits of the vaccine. I am authorized to consent for the person named below:

Patient Name _____ Birthdate _____ Age _____
Address _____
Phone# _____ (Home) _____ (Work)
_____ (Cell)

Is your child 2 years old or older? YES NO
Is this your child's first flu shot? (circle one) YES NO---**Less than 9 years old**____Y____N
Has your child had MMR or chicken pox vaccine within 30 days? YES NO
Is the patient allergic to chicken or eggs? YES NO---(If yes, needs monitoring for 30 minutes)
Is the patient currently experiencing any wheezing or fever? YES NO
Has your child used a medication for wheezing in the past year YES NO
My child has the following chronic illness:_____

I understand that I should call my doctors office if any significant reaction occurs as soon as possible, or if the patient experiences high fever greater than or equal to 102 degrees, vomiting, severe headache, neck pain, or significant muscle weakness.

Parent Signature : _____ Date: _____

FOR OFFICE USE ONLY: OK for Injectable _____ OK for Flu Mist: _____
Physician Initials Physician Initials

MedImmune, Inc –Flu Mist
Lot #
Exp:

Aventis Pasteur Product
Lot #
Exp:

Nurse Initials: _____ Date given: _____

Amount Pd: \$ _____ MC/VISA Cash Check # _____ Initials: _____