PATIENT NAME: **DATE OF BIRTH:**
ADDRESS:
PHONE NUMBER: **PATIENT POLICY #**
INSURANCE COMPANY: **GROUP #**
POLICY HOLDER: **POLICY HOLDER D.O.B.**

Please be aware that North Park Pediatrics will rely upon the above information to bill your insurance company for the influenza vaccination received today. North Park Pediatrics will attempt to bill your insurance only once. If the claim is rejected due to incorrect information supplied above, you will be billed and you will be responsible for paying $25.00 to North Park Pediatrics for the cost of the vaccine and its administration. At that time, if you choose to pursue reimbursement on your own, North Park Pediatrics can supply you with documentation of the administration of the vaccine.

PLEASE ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR CHILD:

My child's age is: ☐ 6months to less than 9 years
☐ 9 years or older

My child has a known allergy to eggs.	☐ yes	☐ no
If yes, were there any symptoms other than hives?	☐ yes	☐ no
If yes, can your child tolerate foods with eggs baked in?	☐ yes	☐ no
My child has had an allergic reaction to the influenza vaccine in the past.	☐ yes	☐ no
My child has a history of Guillain-Barré Syndrome.	☐ yes	☐ no
My child has had a fever in the last 24 hours. (greater than 100.4 orally or 101 rectally)	☐ yes	☐ no
I have read the Influenza Vaccine Information Sheet	☐ yes	☐ no

If your child is less than 9 years old, please answer the following questions:

Has your child had 2 or more seasonal influenza vaccines before July 1, 2018? ☐ yes ☐ no ☐unknown

I, _____, the parent or legal guardian of the above named child, have completed this form. I give my permission for the above named child to receive the influenza vaccine today.

_____ _____
signature date

For office use only: Manufacturer/Lot #

☐ Child to return for second dose