

Patient Information and Consent - Influenza Vaccine

The Children's Clinic is happy to be able to offer flu shots to the immediate family of our patients this year! We hope that you find this a convenient option for immunizing your family against the flu. Please complete and sign this form to allow TCC to administer the flu shot and bill insurance.

Section I: Information about *Person to Receive Vaccine* (please print)

First Name:	Last Name:	M.I.:	Date of Birth:
Address:		Phone Number:	
City, State, Zip:	Gender: M / F	Email address:	

Section II: Information about one *established TCC Patient* (you do not need to list all children)

First Name:	Last Name:	M.I.:	Date of Birth:
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Section III. Insurance - fill out OR present your insurance card for scanning

Insurance Company	Policy Holder's Name:		
Policy Holder Relationship to patient:	Group Number:	Policy Number:	Policy Holder DOB:

Section IV: Screening for Vaccine Eligibility

1. Do you feel sick today? yes no don't know

2. Do you have any health conditions, such as heart disease, diabetes or asthma? yes no don't know
 If yes, please list: _____

3. Do you have allergies to latex, medications, food (eggs) or vaccines? yes no don't know
 If yes, please list: _____

4. Have you ever had a reaction after receiving a vaccination, including feeling faint or dizzy? yes no don't know
5. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barre syndrome other nervous system problem? yes no don't know

6. For women: Are you pregnant or considering becoming pregnant in the next month? yes no don't know

Section V: Consent

I hereby authorize The Children's Clinic, P.C. to provide medical services to the above named patient and to use and release medical information as required for treatment, payment and health care operations. I also assign The Children's Clinic all payments to which I am entitled for medical and surgical expenses. I understand that I am financially responsible for all charges whether covered by insurance or not and that balances will be added to the Guarantor account of my child(ren) or the established patient(s) at TCC. I understand insurance copays are due at the time of service. I have received a copy of the current Privacy Notice and Notice of Referral Rights & Financial Interest of The Children's Clinic.

Name of person receiving flu shot: _____
(please print)

Signature: _____ Date: _____