PATIENT

PARKER PEDIATRICS & ADOLESCENTS
2024-2025 INFLUENZA VACCINE (SHOT) CONSENT

I have had the opportunity to read the CDC Vaccine Information Sheet (VIS), and believe I understand the benefits and risks of the immunizations. I have had the opportunity to ask questions regarding this vaccine. I request it to be given to my child.

The insurance company on file for my child will be billed for this vaccine. I understand that I am financially responsible for any balance not covered by my insurance company, including co-pays and co-insurance.

Patient / Child Name:	**Patient / Child DOB:**

Insurance:

☐ **Aetna** ☐ **BCBS** ☐ **Champ VA** ☐ **Cigna** ☐ **CHP**

☐ **Humana** ☐ **Medicaid** ☐ **Tricare** ☐ **UHC** ☐ **UMR**

☐ **Other - Not Listed Above – Must pay $35 fee for flu vaccine**

Date of Clinic:

X	**PRINT Parent/Patient (if over 18) Name:**
Parent / Patient (if over age 18) Signature	

PLEASE TYPE RESPONSES ABOVE, PRINT THIS FORM, AND BRING TO CLINIC

>>>>>>>>>>>>>>>>>>>>>> FOR OFFICE USE ONLY <<<<<<<<<<<<<<<<<<<<<<

Lot #		Exp Date:		Site: LA RA LL RL
Nurse/MA			Second Shot Needed: ☐ Yes ☐ No	