Influenza Vaccine Permission Form

PLEASE COMPLETELY FILL OUT THE FORM BELOW

Child 's Last Name:-___________________

Child's First Name:-___________________

Printed Name of ParenULegal Guardian: _________________________ _______________________ completing this form

Relationship: _______________________________________

Child's Date of Birth:_____________________________Age:____________________Sex: O Male D Female

Payment policy: $20.00 cash at time of shot.

OR

Dr Colglazier will send to insurance IF You have Insurance.

You must provide the information below to send to insurance.

Insurance Company name:______________________

Insurance policy number: _________________________

Policy Holders Name:_____________________________________

I>arent's-Address: _______________________ Parent's

City:________ State: ______________________ Zip: __________

Parent's Phone Number:-________________________ _______________________________

Please answer YES or NO to all the following questions. If YES, please explain.

1) O Yes O No Is your child allergic to eggs, egg products or flu vaccine?____

2) O Yes Q No Has a doctor ever told you that your child has weakened muscles from Guillain-Barre syndrome?

3) O Yes O No Does your child have a weakened immune system? (e.g., cancer, HIV, Chemotherapy, chronic steroid use)

4) O Yes O No Has your child received any vaccines within the past month or pla n to receive any within the next month'! If yes, please list the vaccine and date administered ____

Comments: ____

By signing below, I u ndersta nd/agree to the following:

- I have received and reviewed *this* consent form and agree that an influenza vaccine be given by Colglazier Clinic by an Intra-muscular route to the above named child for whom I am authorized to make thls request
- I allow my child to receive influenza vaccine (killed virus) by shot in the arm, in my absence.

Pa rent/Legal Gua rdian Sig1 lat ure: ____ Da te: _________________