DATE_____

Charges on_____ **$** posted_____
Office Use Only: VFC 21.68 Check#_____Charge#_____Cash_____30.00 x_____
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Centennial Valley Pediatrics
Consent for Treatment – Injectable Influenza Vaccination

Name of Person receiving the vaccination_____Age_____

Date of Birth_____Address_____

City_____State_____Zip_____Insurance_____

- If this person is a patient of Centennial Valley Pediatrics we will bill the insurance on file.
- If you have new insurance, please have your card copied today at the front desk.
- ____VFC-Check here if you are under 19, a patient of Centennial Valley Pediatrics and have no insurance.
- We are unable to bill Parent and Non-Patient vaccines to insurance and do require payment today. The cost is $30.00. We accept cash, checks, Visa, Mastercard and Discover. Please pay at the front desk prior to receiving the vaccine.

The following 4 questions will help us determine if you or your child should not receive the **Injectable Flu** today. If you answer "YES" to any question it does not mean that you should not be vaccinated, it means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

1. Is the person to be vaccinated sick today? Yes_____ No____
2. Does the person to be vaccinated have an allergy to a component of the vaccine including allergy to egg or Thimerosol? Yes_____ No_____
3. Has the person to be vaccinated ever had a serious reaction to the Influenza or another vaccine in the past? If yes explain reaction: _____ Yes _____ No_____
4. Has the person to be vaccinated ever had Guillain-Barre' syndrome? Yes _____ No_____

NOTE: If this is the **first** year your child is vaccinated with the flu vaccine and is **under the age of 8 years** old your child will need a 2nd vaccine after 30 days. Initial_____

I have read the above information about Injectable Flu and truthfully answered all of the questions. I have had a chance to ask questions and fully understand the benefits and risks of the Injectable. I agree that Centennial Valley Pediatrics shall have no responsibility or liability if I suffer any other adverse reaction following the administration of Injectable Flu.
I have received a copy of the Vaccine Information Sheet (VIS) 2019/2020.

Signature:_____ Date:_____

Patient Name:_____Date of Birth:_____

OFFICE USE ONLY:
EGeorge, RN PLuehrs, RN LScanlan, RN NMcKelvie, LPN JRose, CMA NPablo, CMA NBrizuela, CMA EDelRio, CMA KTirado, CMA CReta, CMA, ABadillo, CMA NMartinez, CMA EMendoza, CMA

Date Vaccination and VIS given: _____
VIS Date: Injectable Flu: 8/15/20

Sanofi PF 0.5ml Flu Vaccine Lot:_____ Exp: 6/30/20 Site:_____

Sanofi Multidose 0.5ml Lot:_____ Exp: 6/30/20 Site:_____

GSK PF 0.5ml Flu Vaccine Lot:_____ Exp: 6/30/20 Site:_____

GSK Multidose 0.5ml Lot:_____ Exp 6/30/20 Site:_____