DATE________________

Charges on______ $ posted________

Office Use Only: VFC 21.68 Check#________Charge#________Cash________40.00 x_______

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Centennial Valley Pediatrics
Consent for Influenza Vaccine
Injectable or Flumist

Name of the 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 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 $40.00. We accept cash, checks, Visa, Mastercard and Discover. Please pay at the front desk prior to receiving the vaccine.

The following 13 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. Have you ever had the Injectable Flu Vaccination or Flumist? Yes_____ No_____
2. Do you currently have a fever, respiratory illness or any type of infection? Yes_____ No_____
3. Does the person being vaccinated have an allergy to eggs or a component of the influenza vaccine including Thimerisal? Yes_____ No_____
4. Has the person being vaccinated ever had a serious reaction to Flumist or another vaccine? If yes explain reaction:___________________________ Yes_____ No_____
5. Is the person being vaccinated under 2 years old or over 49 years old? Yes_____ No_____
6. Does the person being vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (diabetes), anemia or other blood disorders? Yes_____ No_____
7. Is the person being vaccinated a child age 2 to 4 years with history of recurrent wheezing? Yes_____ No_____
8. Does the person being vaccinated have a weakened immune system due to HIV/AIDS or a disease that affects the immune system, long-term treatment with drugs such as steroids or cancer treatment with x-rays or drugs? Yes_____ No_____
9. Is the person being vaccinated receiving Aspirin therapy or Aspirin containing therapy? Yes_____ No_____
10. Is the person being vaccinated pregnant or could become pregnant within the next month? Yes_____ No_____
11. Has the person being vaccinated had Guillian-Barre Syndrome? Yes_____ No_____

(please complete on back side)

Patient Name: ____ Date of Birth: ___________

12. Does the person being vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in a protective environment (such as hospital room with reverse airflow?) Yes_____ No_____
13. Has the person being vaccinated received any other vaccine in the past 4 weeks? Yes_____ No_____

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).

Signature:____
Date:_________________

OFFICE USE ONLY:

EGeorge, RN, PLuehrs, RN, LScanlan, RN, NMcKelvie, LPN, JAsher, MA, ABadillo, CMA, EDelRio, CMA, DKulp, MA, DMarshall, CMA, MMadrigal, MA, KTirado, CMA, NPablo, CMA, CReta, CMA, JRose, CMA

Date Vaccination and VIS given: ___________
Informed to return for #2 vaccine after:__________
VIS Date: Injectable Flu: ___________________

Sanofi PF 0.25ml Pediatric Flu Vaccine Lot:_______________ Exp:____________ Site:___________

Sanofi PF 0.5ml Flu Vaccine Lot:_______________ Exp:____________ Site:___________

Sanofi Multidose 0.50ml Lot:_______________ Exp:_____________Site:__________

FLUMIST One spray (0.10cc) each nostril Medimmune Lot:___________________Exp:__________