NORTH TEXAS ALLERGY & ASTHMA ASSOCIATES

Locations throughout Dallas – Specializing in personalized care since 1927
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FLU VACCINATION AUTHORIZATION

Patient name: ____ Date: ____________________

Date of Birth: ____________________

Cell #: (   ) __________________________

_____ I have had the opportunity to review the Vaccine Information Sheet (VIS), prior to vaccination.

	Yes	No	Don't Know
1. Are you sick today?	☐	☐	☐
2. Have you ever had a serious or allergic reaction to the influenza Vaccine in the past?	☐	☐	☐
3. Have you ever had Guillain-Barre Syndrome?	☐	☐	☐

I hereby authorize the staff of NORTH TEXAS ALLERGY & ASTHMA ASSOCIATES to give me (or the person above for who I am authorized) the Influenza Vaccine and I understand the risks and benefits of vaccination. I agree to release NORTH TEXAS ALLERGY & ASTHMA ASSOCIATES, its physicians and employees from any and all liability for any adverse reaction (including anaphylactic shock or death) that may occur as a result of my receiving the Influenza Vaccine. I have been provided the Vaccine Information Sheet (VIS) which informs me of the potential adverse reactions, and I have read and answered the above questions correctly, to the best of my knowledge. I have been given the opportunity to ask questions and they have been answered to my satisfaction. I agree to WAIT near the flu vaccination location for 15 minutes after receiving the vaccination and accept responsibility for seeking medical attention for any problems that I may encounter with this vaccination. I give permission to release the date of the Influenza vaccine to any health care provider that may need this information.

Insurance and Payment Acknowledgement

_____ I acknowledge that North Texas Allergy and Asthma Associates will file my insurance claim for me. I acknowledge that I will be responsible for any outstanding balance that my insurance company does not cover in regard to the influenza vaccination. I acknowledge that failure to pay an outstanding balance will result in interest and late fees added to my account.

Date: __________Time: _____ Patient Signature: ______________________________________

IF A MINOR, PLEASE COMPLETE THIS SECTION (Parent or legal guardian):

Relationship: ___________ Name: ______________________ Signature: ____________________________

FOR STAFF USE Charge: (30 / 60)

Tech: _________Lot #: ___________ Expiration Date: __________ Age: ____ Temperature: _____Injection (R/L): _____

Amount Received: _____________ Payment Type: ________________ Insurance Billed: ______________

Dose guide by age: ____6-35 months: Fluzone 0.25mL (CPT 90687) ____36 months+: Fluzone 0.5mL (CPT 90687)

____4yo+: Flucelvax 0.5mL (CPT 90756) ____65yo+: Fluad 0.5mL (CPT 90653)

For a child 6 months to 8 years old who has not previously received at least 2 doses of flu vaccine, a 2nd dose is recommended at least 4 weeks later.