INFLUENZA VACCINE CONSENT FORM

Virginia Pediatric Group

FAIRFAX

TODAY'S DATE : _______________

PATIENT NAME: _____________________________ **DATE OF BIRTH:** ______________ **AGE:** __________

MEDICAL STATUS: ____________________ **ALLERGIES:** _________________ **TEMP:** ________________

INJECTION(S) GIVEN: ___________________ **SITE:** _______________ **LOT #** ___________ **EXP:** ________

***** INFORMED CONSTENT FOR ADMINSITRATION OF INJECTION *****

1 – I have been informed of the possible side effects resulting from this injection

2 – I have informed the health professional of my child's known allergies such as eggs or any components of the influenza vaccine.

3 – My signature below constitutes my agreement of the following:

a. That I have read / understand this consent.

b. That I received all information I desire concerning the administration of the injection(s).

c. I understand that insurance coverage of these injections vary depending of plan/medical necessity, therefore upon rejection of this service from my insurance I agree to remit payment in full to Virginia Pediatric Group.

d. **Parental Vaccines**, I understand insurance will not be billed for my Flu shot, I will pay $35.00 for the vaccine.

PARENT SIGNATURE : _____________________________________ DATE : ________________________

Total Paid $_________ Cash________ Check#________ Credit (MC, Visa, Disc, Amex) ________

AGE:	6-35 MO. (prefilled)	36 MO + (prefilled)	6-35 MO.	36 MO +
VACCINE:	90685	90686	90687	90688
ADMIN:	90471	90471	90471	90471
ICD-10 :	Z23	Z23	Z23	Z23

INFLUENZA VACCINE CONSENT FORM

Virginia Pediatric Group

HERNDON

TODAY'S DATE : _______________

PATIENT NAME: _____________________________ DATE OF BIRTH: ______________ AGE: __________

MEDICAL STATUS: ____________________ ALLERGIES: _________________ TEMP: ________________

INJECTION(S) GIVEN: ___________________ SITE: _______________ LOT # ___________ EXP: ________

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ICD-10 :	Z23	Z23	Z23	Z23

INFLUENZA VACCINE CONSENT FORM

Virginia Pediatric Group

GREAT FALLS

TODAY'S DATE : _______________

PATIENT NAME: _____________________________ DATE OF BIRTH: ______________ AGE: __________

MEDICAL STATUS: ____________________ ALLERGIES: _________________ TEMP: ________________

INJECTION(S) GIVEN: ___________________ SITE: _______________ LOT # ___________ EXP: ________

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ADMIN:	90471	90471	90471	90471
ICD-10 :	Z23	Z23	Z23	Z23

INFLUENZA VACCINE CONSENT FORM

Virginia Pediatric Group

ALDIE

TODAY'S DATE : _______________

PATIENT NAME: _____________________________ DATE OF BIRTH: ______________ AGE: __________

MEDICAL STATUS: ____________________ ALLERGIES: _________________ TEMP: ________________

INJECTION(S) GIVEN: ___________________ SITE: _______________ LOT # ___________ EXP: ________

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