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 ADMINS	SITRATION OF INJECT	ION ****		
1 – I have been informed of the possible signal	de effects resulting fi	om this injection		
2 – I have informed the health professiona	l of my child's known	allergies such as eggs	s or any components of	
the influenza vaccine.				
3 – My signature below constitutes my agr	eement of the follow	ing:		
a. That I have read / understand this con	isent.			
b. That I received all information I desire	concerning the adm	inistration of the injec	tion(s).	
c. I understand that insurance coverage	of these injections va	ry depending of plan/	medical necessity, therefore	
upon rejection of this service from my in	nsurance I agree to re	emit payment in full to	Virginia Pediatric Group.	
d. Parental Vaccines, I understand insura	ance will not be bille	d for my Flu shot, I wil	l pay \$35.00 for the vaccine.	
PARENT SIGNATURE :		DATE :		

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

Virginia Pediatric Group

HERNDON

	TODAY'S DATE :		
PATIENT NAME:	DATE OF BIRTH:		_ AGE:
MEDICAL STATUS:	ALLERGIES:	ТЕМР: _	
INJECTION(S) GIVEN:	_ SITE:	LOT #	EXP:
***** INFORMED CONSTENT FOR ADMINSIT	RATION OF INJECTIO	DN ****	
1 – I have been informed of the possible side	e effects resulting fro	om this injection	
2 – I have informed the health professional c	of my child's known a	allergies such as eggs o	or any components of
the influenza vaccine.			
3 – My signature below constitutes my agree	ement of the followi	ng:	
a. That I have read / understand this conse	ent.		
b. That I received all information I desire c	oncerning the admir	nistration of the injecti	on(s).
c. I understand that insurance coverage of	these injections var	y depending of plan/m	edical necessity, therefore
upon rejection of this service from my ins	urance I agree to rer	mit payment in full to \	/irginia Pediatric Group.
d. Parental Vaccines, I understand insuran	ice will not be billed	for my Flu shot, I will p	bay \$35.00 for the vaccine.
PARENT SIGNATURE :		DATE :	

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

Virginia Pediatric Group

GREAT FALLS

		TODAY'S DAT	E:
PATIENT NAME:	DATE OF BIRTH:		AGE:
MEDICAL STATUS:	ALLERGIES:	TEMP:	
INJECTION(S) GIVEN:	SITE:	LOT #	EXP:
***** INFORMED CONSTENT FOR ADMINSIT	FRATION OF INJECT	ION ****	
1 – I have been informed of the possible side	e effects resulting f	rom this injection	
2 – I have informed the health professional of	of my child's knowr	allergies such as eggs	s or any components of
the influenza vaccine.			
3 – My signature below constitutes my agree	ement of the follow	/ing:	
a. That I have read / understand this conse	ent.		
b. That I received all information I desire c	concerning the adm	inistration of the injec	tion(s).
c. I understand that insurance coverage of	f these injections va	ary depending of plan/	medical necessity, therefore
upon rejection of this service from my ins	surance I agree to r	emit payment in full to	Virginia Pediatric Group.
d. Parental Vaccines, I understand insurar	nce will not be bille	d for my Flu shot, I wil	l pay \$35.00 for the vaccine.
PARENT SIGNATURE :		DATE :	

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

Virginia Pediatric Group

ALDIE

	TODAY'S DATE :		
PATIENT NAME:	DATE OF BIRTH:		AGE:
MEDICAL STATUS:	ALLERGIES:	TEMP:	
INJECTION(S) GIVEN:	SITE:	LOT #	ЕХР:
***** INFORMED CONSTENT FOR ADMINSIT	TRATION OF INJECT	ION ****	
1 – I have been informed of the possible side	e effects resulting f	rom this injection	
2 – I have informed the health professional of	of my child's knowi	n allergies such as eggs	or any components of
the influenza vaccine.			
3 – My signature below constitutes my agree	ement of the follow	ving:	
a. That I have read / understand this conse	ent.		
b. That I received all information I desire c	concerning the adm	inistration of the injec	tion(s).
c. I understand that insurance coverage of	f these injections v	ary depending of plan/	medical necessity, therefore
upon rejection of this service from my ins	surance I agree to r	emit payment in full to	Virginia Pediatric Group.
d. Parental Vaccines, I understand insurar	nce will not be bille	d for my Flu shot, I will	pay \$35.00 for the vaccine.
PARENT SIGNATURE :		DATE :	

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