NORTH TEXAS ALLERGY & ASTHMA ASSOCIATES

Locations throughout Dallas – Specializing in personalized care since 1927
Main: (214) 369-1901 ~ Fax: (214) 369-1905
Web: www.texasallergy.com

FLU VACCINATION AUTHORIZATION FORM

Patient name: _____ Date: _____

Date of Birth: _____ Cell #: ( ) _____

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

		Yes	No
1.	Do you currently have fever, chills, cough, difficult breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea??	_____	_____
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?	_____	_____
4.	In the past 14 days, have you tested positive for COVID-19?	_____	_____
5.	In the past 14 days, have you been in close contact with anyone who tested positive to COVID-19?	_____	_____

I hereby authorize the staff of NORTH TEXAS ALLERGY & ASTHMA ASSOCIATES (NTAAA) 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 NTAAA, 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 NTAAA 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.

Time: _____ Patient Signature: _____

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

Relationship: _____ Name: _____ Signature: _____

FOR STAFF USE Charge: (30 / 65)

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) ____36 months+: Fluzone 0.5mL (CPT)

____2yo+: Flucelvax 0.5mL (CPT 90756) ____65yo+: Fluad 0.5mL (CPT 90694)

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.