Mount Pleasant Pediatrics
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INFLUENZA VACCINE ADMINISTRATION RECORD 2024-2025 SEASON

Patient's Full Name (Please PRINT) _____

Date of Birth: _____ Age of Patient _____

Patient's regular physician _____

Contact Phone Number _____

Has your child ever had the flu vaccine before? **Yes** **No**

Do you want us to file this visit with your insurance? **Yes** **No**

Name of Insurance plan: _____

If you have had a **serious allergic reaction to eggs or a previous dose of influenza vaccine**, have a **history of Guillain-Barre Syndrome** or have a **current fever greater than 101**, we will **not** be able to administer the flu vaccine today.

Your insurance company will be billed for the total amount of today's visit. You will be responsible for any co-payment, deductible, co-insurance payments as well as any charges denied by your insurance company.

I agree to the terms discussed above. I have read, or have had explained to me information about influenza and the influenza vaccine. I understand the benefits and risks of the influenza vaccine and ask that this vaccine be administered to me today.

_____

Signature Date

Office Use Only

Dose	0.5ml
Lot #	
Exp Date	
VIS Date	08/2021

Insurance	
PVT	VFC

Vaccine	Fluzone
Manufacturer	Sanofi
Admin Fee:	90460
CPT:	90686

Site	
LD	LT
RD	RT

Vaccine Administrator Sig. _____