Pediatrics at the Meadows P.C
Pediatric & Adolescent Healthcare

Adult Flu Shot Form

Please complete all fields

Parent Name:_____D.O.B.____/____/____

Child's Name:_____D.O.B.____/____/____

(Important, please note: Your child's name helps us link the information in our system)

IF YOUR INSURANCE COVERAGE IS DIFFERENT FROM YOUR CHILD'S, PLEASE COMPLETE INFORMATION BELOW

Subscriber/Policyholder Name_____D.O.B.____/____/____

Name of Insurance Plan_____

I.D.#_____ Group #_____

Claims Address_____

I authorize Pediatrics at the Meadows, P.C. to release any information, including diagnosis and treatment records to my insurance company. I authorize my insurance company to pay benefits directly to Pediatrics at the Meadows, P.C. and its physicians.

I have read or have had explained to me the information contained in the Vaccine Information Statement (VIS) about disease and vaccines. I have had the chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and request that the vaccine indicated be given to me. I have never had a severe reaction (anaphylactic) to eggs, have never had a serious allergic reaction to a previous dose of flu vaccine, nor ever had a history of Guillain-Barre Syndrome.

_____ ____/____/____

Signature Date

For Office Use: Lot #_____