



Pediatrics at the Meadows, P.C.

Adult Flu Shot Form

Please complete form in its entirety

Parent Name: _____ D.O.B. ___/___/_____

Child's name: _____ (this helps up link info on our system)

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Do you have the same insurance coverage as your child? Yes No

If no, please tell us the name of the parent whose employer provides this insurance coverage:

First: _____ Last: _____

D.O.B. ___/___/_____

Name of insurance plan: _____

Claims Address: _____

I.D. # _____ Group # _____

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 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 do not have an allergy 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

For Office Use: Lot #

Date