

BEITTEL-BECKER PEDIATRIC ASSOCIATES
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D Brown DO G Laube MD S Crooks MD
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Flu Shot Visit Parent/Guardian

Adults Name:	DATE OF BIRTH:	Age:
<u>Does the above listed person have...?</u> ☐ Yes ☐ No A serious allergy to eggs or egg products? ☐ Yes ☐ No A fever over 101°? ☐ Yes ☐ No A past severe reaction to the flu shot? ☐ Yes ☐ No A history of Guillain Barre Syndrome? ☐ Yes ☐ No Taking an aspirin regimen prescribed by a doctor? ☐ Yes ☐ No Taking a medication prescribed by a doctor List: _____ ☐ Yes ☐ No Contact with a transplant patient? ☐ Yes ☐ No Asthma requiring medicine in last year? ☐ Yes ☐ No Chronic Illness such as: heart disease, diabetes, kidney disease, immune system, or hemoglobin disorder, Other: _____? ☐ Yes ☐ No Are you pregnant or breastfeeding? ☐ Yes ☐ No Received the MMR or Chicken Pox vaccine in the last month? I have read and I understand the information given to me, including the Vaccine Information Statement (VIS). I have had a chance to ask questions, which were answered to my satisfaction. I believe that I understand the benefits and risks of taking the flu vaccine, and I request that the vaccine be given to me or to the person named for whom I am authorized to sign. I also understand that Beittel-Becker Pediatric Associates will not bill my insurance and that this shot is being provided as a courtesy to me. No receipt of vaccination will be given. Signature: _____ Date: _____		
FOR OFFICE USE: ☐ Flulaval QIV PF ☐ Flumist QIV PF 0.5 ml (90656) (90672) Administered By: _____ Administered: ☐ LA ☐ RA ☐ Intranasal Lot #: _____ Exp: _____ ☐ \$45 Fee collected by: _____		