PATIENT

PARKER PEDIATRICS & ADOLESCENTS
2022-2023 INFLUENZA VACCINE (SHOT)
CONSENT

I have had the opportunity to read the CDC Vaccine Information Sheet (VIS), and believe I understand the benefits and risks of the immunizations. I have had the opportunity to ask questions regarding this vaccine. I request it to be given to my child.

The insurance company on file for my child will be billed for this vaccine. I understand that I am financially responsible for any balance not covered by my insurance company, including co-pays and co-insurance.

Patient / Child Name:	**Patient / Child DOB:**
Insurance: ☐ **Aetna** ☐ **BCBS** ☐ **BHP** ☐ **Champ VA** ☐ **Cigna** ☐ **CHP** ☐ **Cofinity** ☐ **Humana** ☐ **Medicaid** ☐ **Tricare** ☐ **UHC** ☐ **UMR** ☐ **Motive Health-DPS Schools** ☐ **Other - Not Listed–$65 fee for flu vaccine**	
Date of Clinic:	
X	**PRINT Parent/Patient (if over 18) Name:**
Parent / Patient (if over age 18) Signature	

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Lot #		Exp Date:		Site: LA RA LL RL
Nurse/MA		Second Shot Needed: ☐ Yes ☐ No		