# FLU ADMINISTRATION FORM 2021-2022
# Blue Ridge Pediatric & Adolescent Medicine, Inc. (BOONE Location)

**Patient's Name** | **Patient's DOB:** | **AGE:**

**Phone Number:** | **TODAY'S DATE:**

## INSURANCE

**INSURANCE TYPE:** | **MOTHER'S MAIDEN NAME:**

## FLU INJECTION (SHOT) OR FLUMIST (NASAL)

**PLEASE ANSWER ALL THE FOLLOWING: PLEASE CIRCLE:**

| | | |
|---|---|---|
| 1. Is your child over 2 years of age and would like to receive the Flu Mist? | YES | NO |
| 2. Does your child have any acute/chronic medical conditions such as heart disease, diabetes, asthma, cancer or any condition that affects their immune system? (this could prevent them from getting flumist) | YES | NO |
| 3. Have you gotten any other vaccines in the past 2-4 weeks? | YES | NO |
| 4. Does your child have an allergy to latex? | YES | NO |
| 5. Does your child have an allergy to eggs? | YES | NO |
| If number 5 is YES- Has your child had a flu vaccine before? | YES | NO |

If yes, you will be required to have a **30 minute wait** after injection.
If no prior Flu Vaccine, then an appointment MUST be made with a doctor before a Flu Vaccine can be administered.

***I have read or have had explained to me the information about the vaccines offered. I have had a chance to ask questions and have them answered to my satisfaction. I understand the risk and benefits of the flu vaccine and request administration of said vaccine to the above named child for who I am authorized to make this request. I understand that Blue Ridge Pediatric and Adolescent Medicine, Inc. will file my insurance; however, if my insurance does not cover the fee of the flu vaccine/ flu mist I will be responsible for payment.***

**Parent's/Guardian's Signature** | **Date**

## OFFICE USE ONLY

**FLUMIST (90672)** **INJECTION (90686)**

**STATE PRIVATE**

**LOT NUMBER: _____ SITE: _____ NURSE: _____**

**Circle When Completed:** **NCIR** **EMR** **BILLING**