FLU ADMINISTRATION FORM 2023-2024
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 asthma and are they having an acute asthma attack? 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

MIST (90672) INJECTION (90686)

STATE PRIVATE

LOT NUMBER: _____ SITE: _____ NURSE: _____

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