Receptionist initials: _____

INFLUENZA VACCINES 2025/2026

Patient's name: _____ **Patient's date of birth:** _____

Patient should receive: Flu shot / Flumist (must be at least 2 years of age)

Has patient received an injection in the last 30 days? Yes / No

Has patient had any adverse reactions to the flu vaccine in the past? Yes / No

*If yes, please explain:

_____

Your health insurance may not pay for the requested item(s) or service(s). The plan that you have chosen does not necessarily cover all of your health care costs. Insurance only pays for covered items and services. The fact that insurance may not pay for a particular service does not mean that you should not receive it, especially if your physician recommends that you receive this service. Self-pay cost for flu shot and flumist for ages 19 and older: $30.

Vaccine Information Statement Sheets have been made available if requested, and I have had a chance to ask questions. I understand the benefits and risks and request that the vaccine(s) be given to me or to the person named above for whom I am authorized to sign.

Responsible party signature:

_____

FOR OFFICE USE ONLY:

Insurance: VFC / Private

Date of vaccination: _____

Route: LA / RA / LT / RT

Staff initials: _____