Pediatrics at the Meadows P.C
Pediatric & Adolescent Healthcare

Pediatrics at the Meadows, P.C.

Adult Flu Shot Form

Please complete form in its entirety

Parent Name:_____D.O.B.___/___/_____

Child's name:_____(this helps up link info on our system)

Street Address:_____

City:_____State:_____Zip:_____

Phone:_____

Insurance Information (PLEASE INCLUDE INFO FOR PRIMARY INSURED)

First Name:_____Last Name:_____

D.O.B. ____ /____ /_____

Name of Insurance plan:_____

Claims Address:_____

I.D. #_____Group #_____

I authorize Pediatrics at the Meadows, P.C. to release any information, including diagnosis and treatment records to my insurance company. I authorize my insurance company to pay benefits directly to Pediatrics at the Meadows, P.C. and its physicians.

I have read or have had explained to me the information contained in the Vaccine Information Statement about disease and vaccines. I have had the chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and request that the vaccine indicated be given to me. I do not have an allergy to eggs, have never had a serious allergic reaction to a previous dose of flu vaccine, nor ever had a history of Guillain-Barre Syndrome.

_____ _____

Signature Date

For Office Use: Lot #