SMITHFIELD PEDIATRICS

Dinusha Dietrich, M.D., F.A.A.P.
Jennifer Barton, PA-C

7 Smith Avenue Suite 103
Greenville, RI 02828

Phone: (401) 231-3138
Fax: (401) 231-4757

2023-2024 SEASONAL INFLUENZA CONSENT FORM

(18 and over)

(Statement of Understanding, Permission, and Agreement)

Patient Last Name: **Patient First Name:** **D.O. B**

Address:

(Please complete all sections of this form)

STATEMENT OF UNDERSTANDING: I have read and I understand the information provided to me about receiving vaccines for influenza, and I have had the opportunity to ask questions. I understand that being allergic to eggs may be a reason for not receiving the influenza vaccine. I affirm to the best of my knowledge that the following questions have been answered truthfully:

		Circle Yes or No	
1.	Are you allergic to EGGS?	Yes	No
2.	Have you had a serious allergic reaction to influenza vaccine?	Yes	No
3.	Do you have a history of Guillain-Barre' Syndrome?	Yes	No
4.	Do you have asthma?	Yes	No
5.	Do you have a latex allergy?	Yes	No

STATEMENT OF PERMISSION AND ASSIGNMENT: I voluntarily give *my* permission to receive the influenza vaccine. I understand that payment for this service may be made in accordance with the provisions of Title XVIII of the Social Security Act (Medicare), and /or Title XIX of Social Security Act (Medicaid), and /or private insurance or third-party payer. I hereby authorize the provider of service to release information necessary for the processing of any claim for payment made on behalf, and I authorize payment to the provider for such claim. I understand that I am responsible for any costs incurred that are not covered by a third-party payer.

Signature (Patient or Guardian) Date