

SMITHFIELD PEDIATRICS

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2024-2025 SEASONAL INFLUENZA CONSENT FORM

(Statement of Understanding, Permission, and Agreement)

Childs Last Name: _____ Childs 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. Is your child allergic to EGGS? | Yes | No |
| 2. Has your child had a serious allergic reaction to influenza vaccine? | Yes | No |
| 3. Does your child have a history of Guillain-Barre' Syndrome? | Yes | No |
| 4. Does your child have asthma? | Yes | No |
| 5. Does your child have a latex allergy? | Yes | No |

STATEMENT OF PERMISSION AND ASSIGNMENT: I voluntarily give *my* permission for my child 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 (Parent or Guardian)

Date