SMITHFIELD PEDIATRICS

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2022-2023 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