

SUBURBAN PEDIATRICS INFLUENZA SCREENING FORM/ABN

(Please print legibly)

LAST NAME: _____ FIRST NAME: _____

D.O.B. _____ AGE: _____

PRIMARY INSURANCE: _____

Disclaimer: Vaccination is based on your answers to the following questions.

Is your child allergic to eggs or any component of the influenza vaccine?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Is your child ill or have a fever today? (mild cold symptoms without fever are not a contraindication to receive the flu vaccine)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Has your child ever had a severe reaction to a previous dose of the flu vaccine?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Does your child have any history of Guillain Barre' Syndrome, an illness associated with paralysis?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

If you answered YES to any of the questions above, your child will NOT be able to receive the flu vaccination.

Advanced Beneficiary Notice

Note: You will need to make a choice about receiving these health care items or services.

Your health insurance may not pay for the item(s) or service(s) that are described below. Health insurers do not necessarily pay for all of your health-care costs. Insurance only pays for covered items and services. The fact that insurance may not pay for a particular item or service does not mean that you should not receive it, especially if your physician recommends that you receive this item or service.

Description of Item(s) or Service(s):	
Seasonal Influenza Vaccine	Estimated Cost: \$35.00

The purpose of this notice is to help you make an informed choice about whether you want to receive these items or services, knowing that you might have to pay for them yourself. By signing below, you agree to take financial responsibility for the cost of the item(s) or service(s) in the event your health insurance does not include this as a covered item or service.

Printed Name of Parent/Legal Guardian

Signature of Parent/Legal Guardian **Date**

Employee/Witness Signature **Date**

Office Use Only			
<u>Stock</u>		<u>VFC</u>	
90655	6 – 35 months	90655V	6 – 35 months
90656	36 months and older	90656V	36 months and older
90460	Immunization Administration	Nurse Documented:	_____
		Staff Charge Entry:	_____