Bloomington Pediatrics 306 St. Joseph Dr., Bloomington, IL 61701 Phone: 309-662-0504

BLOOMINGTON PEDIATRICS CLIENT VACCINATION REGISTRATION FORM

Today's Date ____/____/_____

CLIENT: Last Name	First Name	MI	Birth Date	Male Female

Address (if different from your child's)	City	ZIP Code	Telephone Number
Name of Emergency Contact	**Relationship to Client**		**Telephone Number**

Insurance (If different from your child's)
Aetna Blue Cross/Blue Shield Cigna Health Alliance Humana United Healthcare
Other:

Member Number on Card	Group Number	Relationship to Client
Member Name (if different from client)	**Birth Date**	**Member Employer**
Additional Information	**Member's Address (if different from client)**	

ASSIGNMENT OF BENEFITS: I understand that Bloomington Pediatrics will bill a charge to my insurance for the flu vaccine and administration. I request that payment of authorized insurance company benefits be made to Bloomington Pediatrics for any services furnished to me by Bloomington Pediatrics. I understand that Bloomington Pediatrics is authorized to use the information gained during treatment to bill me or my insurance company. I also hereby acknowledge that I was offered and/or received a copy of the "Notice of Privacy Practices" from Bloomington Pediatrics. My signature indicates agreement to the above and that all information provided above is true/accurate:

_____ _____

Signature of Client or Legal Representative ***Date***

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BLOOMINGTON PEDIATRICS

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CONSENT FORM FOR SEASONAL INFLUENZA (FLU) VACCINE

I have read or have had explained to me the information about influenza and influenza vaccine. I have had an opportunity to discuss the benefits and risks of influenza vaccine with a healthcare provider of my choice before coming
here today. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of influenza vaccine and request that the vaccine be given to ☐ ME.

Please print:

Name:_____ **DOB:** _____

Has the person receiving the vaccine ever had an allergic reaction after a previous dose of influenza vaccine, allergic to a vaccine ingredient, or had any severe, life-threatening allergies

☐ YES ☐ NO

If yes, please explain: _____

Does the person receiving the vaccine have a history of Guillain-Barré syndrome or a persistent neurological illness?

☐ YES ☐ NO

If yes, please explain: _____

Is the person receiving the vaccine pregnant? ☐ YES ☐ NO

_____ _____

Signature of person receiving vaccine **Date**

DO NOT WRITE IN THIS SPACE—OFFICE USE ONLY VIS Edition Provided: CDC Version 8/6/2021

Lot number: _____Expiration Date:_____

CHECK ONE:

____Patient 3+ years/Adults 0.5 mL IM Quadravalent Influenza Virus Vaccine given in **L** **R** deltoid

____Patient 6-35 months: 0.25 mL IM Quadravlalent Influenza Virus Vaccine given **L** **R** quadriceps

____Patient 2+ years: Flumist Influenza Virus Vaccine given