Preston Ridge Pediatric Associates

Influenza Vaccine Consent Form for PARENTS

Date: ____________________________________

Parent's Name: ____________________________________

Parent's Date of birth: ____________________________________

Marital Status (circle one): Married Single Divorced Widow(er)

I am covered under the same insurance policy as my children (circle one): YES NO

I am the (circle one): Policy Holder **OR** Dependent Spouse

Attention - Please complete this section so that we accurately bill your current insurance company:

Insurance Carrier*: ____

***(Please Note if you are covered under Anthem/Blue Shield HMO, we are unable to bill the insurance as we are not your primary care provider and would be considered out of network.)**

If you are NOT covered under the same insurance as your children:
Please list carrier: ____
AND Provide copy of card to front desk. Thank you!

Family Information (so that we connect you to the correct children/family, please provide at least one child's name and date of birth):

Child's Name/Date of Birth: ____

Child's Name/Date of Birth: ____

I consent to receive a flu vaccination and I understand that Preston Ridge Pediatrics will file a claim with my insurance plan for the Influenza vaccine I receive today. If my insurance does not pay the charge, I agree that I am responsible for payment for this service.

____ ________________________
Signature **Date**

For Internal Use:

☐ **Flu Vaccine Given** **Nurse Initial Here:** __________