BLOOMFIELD PEDIATRIC CARE 43205 Woodward Ave Bloomfield Hills, MI 48306 Telephone (248) 451-0600 Fax (248) 451-0700

Influenza Vaccination Informed Consent

Name of Patient

Birthdate

1. Have you ever had an allergic reaction to eggs?

□ Yes□No □Not Sure

2. Are you sick right now with something other than a cold?

□ Yes□No □Not Sure

3. Have you ever had a "bad reaction" to the influenza vaccination?

□ Yes□No □Not Sure

4. Are you pregnant?

□ Yes□No □Not Sure

I have read the "Influenza Vaccination Facts" and would like to receive the influenza vaccination.

Patient's/Parent's Signature_____

Date

Patient's Name:	
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Insurance Co.:

Advance Beneficiary Notice (ABN)

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. The plan that you have chosen as your health insurer does not necessarily cover all of your health-care costs. Insurance only pays for covered items and services. The fact that insurance may not pay for a particular service does not mean that you should not receive it, especially if your physician recommends that you receive this service.

Description of Item(s) or Service(s):	
Estimated Cost:	

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), if your health insurance does not include this as a covered item(s) or service(s).

Responsible party signature:

Date:

	VACCINE ADMINISTERED				VACCINE		VACCINE INFORMATION			
VACCINE	Date Patie	Patient	Patient Site on	FUNDING SOURCE	Lot		STATEMENTS Date Date		Vaccine Administrator	Parent/ Guardian
(fill In)	m/d/y	Age	Patient*	(F,S,P)†	Manufacturer	Number	Published	Provided	initials‡	initiais‡
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