Patient Name:_____ Date of birth:_____/_____/_____

Screening Questionnaire for Inactivated Injectable Influenza Vaccination

The following questions will help us determine if there is any reason you should not receive an inactivated injectable influenza vaccine today. If you answer "yes" to any questions, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1.) Are you/your child sick today?	☐	☐	☐
2.) Do you/your child have an allergy to eggs or to a component of the vaccine?	☐	☐	☐
3.) Have you/your child ever had a serious reaction to an influenza vaccine in the past?	☐	☐	☐
4.) Have you/your child ever had Guillain-Barre syndrome?	☐	☐	☐
5.) If applicable, are you or do you suspect you are pregnant? If yes, what trimester? _____	☐	☐	☐

By signing this form, I acknowledge that I have been made aware of the benefits and risks associated with receiving the Inactivated Influenza vaccination. In addition, I acknowledge that I have read and/or received a copy of the vaccine information statements (VIS).

_____ _____

Signature of patient/parent Date

_____

Patient/Parent Name (please print)

FOR OFFICE USE ONLY

Vaccine:_____ Date on VIS:_____

Date given:_____ Date VIS given:_____

Site:_____

Vaccine Lot#:_____ _____

Vaccinator's signature or initials

Healthy Pediatrics at Old Bridge, LLC
3 Athens Avenue
South Amboy, NJ 08879

Last Name: _____ First Name: _____ Date Of Birth: ____/____/____

Address:_____ City: _____ State: _____ Zip: _____

Home Phone#: (___)_____ Cell#: (___)_____ Work#: (____) _____

MEDICAL INSURANCE INFORMATION

Are you covered by insurance?
☐ Yes ☐ No

Primary Insurance:_____ Subscriber's Name:_____

Subscriber's Date of Birth:____/_____/_____ Relationship to Subscriber:☐ Self ☐Spouse☐ Other_____

Co-Pay: $_____ Policy ID#:_____ Group#:_____

Secondary Insurance: _____Subscriber's Name:_____

Subscriber's Date of Birth: _____/_____/_____ Relationship to Subscriber:☐Self ☐Spouse ☐Other_____

Co-Pay:$_____ Policy ID#:_____Group#:_____

INSURANCE COVERAGE WAIVER

I understand that my eligibility for coverage by the insurance(s) named in the MEDICAL INSURANCE INFORMATION section of this document may not be confirmed at this time. I wish to receive medical services from Healthy Pediatrics at Old Bridge, LLC. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

ASSIGNMENT OF INSURANCE BENEFITS/RELEASE OF MEDICAL INFORMATION

I hereby assign to Healthy Pediatrics at Old Bridge, LLC any insurance benefits available for health care services provided to me. If these benefits are not assigned to Healthy Pediatrics at Old Bridge, LLC, I agree to forward all health insurance payments that I receive for services rendered immediately to Healthy Pediatrics at Old Bridge, LLC.

I authorize Healthy Pediatrics at Old Bridge, LLC to release the minimum necessary medical or other information to persons employed or retained by or affiliated with Healthy Pediatrics at Old Bridge for purposes of my diagnosis and treatment that may be required in order to process insurance payment. I agree that these provisions will remain in effect until I provide written notice to Healthy Pediatrics at Old Bridge that this authorization has been changed or discontinued.

_____ _____

Signature of Patient Date