FLU VACCINE WAIVER FOR NEW OR NON-PATIENTS

Date: _____/_____/_____ Name _____ DOB: _____/_____/_____

Age: _____ Allergies: _____ Current Medications: _____

First & last name of patient in our practice: _____ PCC #: _____

Diagnosis Code = V04.81

Regardless of whether or not your health insurance will reimburse for the Flu Vaccine you are requesting these services at your own expense, since you are not a patient at our practice. You will be responsible for payment at the time the flu vaccine is administered.

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1. Have you ever had?
   - A serious allergic reaction to egg or egg products (hives, swelling of the lips or tongue, difficulty breathing, shock)? YES NO
   - A serious allergic reaction to a previous flu vaccine? YES NO
   - Guillain-Barré Syndrome GBS – a serious neurological condition? YES NO

2. Is the person receiving this vaccine currently sick? YES NO

3. Are you requesting Flu Mist nasal spray? (approved only for 2-49 years of age) YES NO

If yes, please answer the following questions

- Do you have asthma? YES NO
- Have you had one or more episodes of wheezing within the past year? YES NO
- Are you taking Aspirin or aspirin-containing medications? YES NO
- Are you or someone you care for immuno-compromised? (low immunity to fight diseases) YES NO
- Is the person receiving this vaccine pregnant? YES NO N/A
- Have you used albuterol inhaler or nebulizer in the last year? YES NO
- Have you received a live vaccine (Varivax or MMR) within the last 28 days? YES NO

_____ _____

Signature of Parent/Guardian Date

To be completed by office staff:

VALID ID VERIFIED (mandatory if administering Flu Mist)**:** _____

nurse initials

Check ☑	Code	Product	Pres. Free	Ages	Dose	Lot	Exp. Date	Charge
	90672	FLUMIST	Yes	2yr-49 yr	0.2ml nasal			**$40.00**
	90685	Fluzone	Yes	6-35 months	0.25ml Prefilled Pres Free			**$40.00**
	90686	Fluzone	Yes	>35 months	0.5 Prefilled Pres Free			**$40.00**
	90687	Fluzone	No	6-35 months	0.25 ml Multi-dose Vial			**$40.00**
	90688	Fluzone	No	>35 months	0.5 Multi-dose Vial			**$40.00**

Date Administered: _____ Administered By: _____

Total Charge $: _____ CASH CC CHECK # _____