Somerset Pediatric Group

Patient Name:_______________________________ DATE VIS sheet offered _______________

Age:_________________________Date of Birth _______________________

Does your child have any medical conditions? Y N

If yes, indicate conditions____

Has your child ever had the Flu vaccine / Flu Mist Y N Any reactions? ______________________

Is your child allergic to eggs or chicken? Y N

If yes, what type of reaction did they have? ____

All of our vaccine is preservative free

I have been made aware that my insurance company may not reimburse for the Flu vaccine if they do not recognize it as a medically necessary treatment.
I, therefore, understand that it may be necessary to pay for this vaccine if my insurance company does not reimburse for that vaccine.

SIGNATURE	DATE	RELATIONSHIP

FluLaval Quad 90686

GSK

0.5cc IM

Lot# XD234

6/30/21

Initials _____________

VIS Sheet published 8/15/19 given

FluLaval Quad 90686

GSK

0.5cc IM

Lot# ___________ 6/30/21

Initials _____________

VIS sheet published 8/15/19 given