THIS FORM MUST BE **COMPLETELY** FILLED OUT IN ORDER FOR YOU TO RECEIVE A FLU SHOT

VILLAGE PEDIATRICS OF CHAPEL HILL, P.A.
2011 FLU SHOT

(Please Print)

Today's date:	My child IS a patient of VP________ My child is NOT patient of VP______

PARENT/GUARDIAN INFORMATION

Last:	First:	M.I.:	NCDL or SSN(required):	☐ M ☐ F
Street Address:		City:		State:
Home: ( )	Cell: ( )	DOB: _______/_______/________		Zip Code:

Pharmacy:	EGG OR GENTAMICIN ALLERGY IN YOUR FAMILY? Yes____No____

FAMILY MEMBERS RECEIVING FLU SHOT TODAY

1. Patient Name:	DOB: _____/_____/______	Temperature:
2. Patient Name:	DOB: _____/_____/______	Temperature:
3. Patient Name:	DOB: _____/_____/______	Temperature:
4. Patient Name:	DOB: _____/_____/______	Temperature:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Primary Insurance Card Attached? [ ]	Policyholder/DOB:
Other Insurance Card Attached? [ ]	Policyholder/DOB:

I certify that all the above information is correct. I request that payment for services be made to VILLAGE PEDIATRICS OF CHAPEL HILL, P.A. I also authorize release of information needed to determine benefits payable for related services to VILLAGE PEDIATRICS OF CHAPEL HILL, P.A. and any other physician who is presently or may at times provide treatment for me or my dependent's.

Parent Signature: ____ Date: ______/_______/________

My signature below indicates that I have been given the opportunity to read VILLAGE PEDIATRICS OF CHAPEL HILL, P.A. "Notice of Privacy Practices". My signature means that I agree to allow VILLAGE PEDIATRICS OF CHAPEL HILL, P.A. to use & disclose personal health information to carry out treatment, health care operations and payment.

Due to the Privacy Act, please list names of anyone you would like to have access to your medical information. Please understand that without your consent, we will deny any requests for information to family members. Only the names listed below will be given any information regarding your medical condition. If you do not want anyone to have access, please write "none" below.

Parent Signature: ____ Date: ______/_______/________

Additional Names: _______________________________ _________________________________

VACCINE INFORMATION STATEMENT

TO BE FILLED OUT BY VILLAGE PEDIATRICS OF CHAPEL HILL, P.A.

Eligi-bility Status	Vaccine Administered	Date Admin.	Admin. Site/Route	Mrs. And Lot No.	Expiry Date	Contra-indication	Consent or Authorization Signature	Providers Initials	Date Printed on VIS
1									
2									
3									
4									

Rev.10/08