

Name: _____

Date of Birth: ___/___/___

FLU FORM

Please check all the reasons why you are getting a flu vaccine or flumist:

- | | |
|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Health Care Worker |
| <input type="checkbox"/> Other Lung Disease | <input type="checkbox"/> Over the age of 65 |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> For General Flu Prevention |

Are you allergic to eggs? Yes No

Have you ever had a bad reaction to a flu vaccine?
 Yes No Never had a flu vaccine before

Please note that we will submit your flu vaccine to insurance
only if in conjunction with an office visit.

Charges are as follows:

Flu vaccine: \$25 ▪ Pedi flu vaccine: \$30 ▪ Flumist: \$30

I understand the above office policy regarding flu vaccines
and hereby state that I am not allergic to eggs.

Signature: _____

Date: _____