CAMPGROUND Pediatrics Wellness CENTER

Flu & COVID Clinic Form

Clinic Date: _____

Patient Name: _____ DOB: _____

Is this a new patient to the practice*** Yes No **This clinic is for established patients only or their parents

Address: _____
Street City Zip Code

Phone Number: _____ Email : _____

Name of Insurance: _____ Policy #_____

Has your insurance changed since your last visit in the office ? Yes No

Who will be driving the patient in for the flu vaccine?_____

1. Is this the patient's first flu vaccine**? Yes No
   ** If your child is 8 years old or younger and has not ever received flu vaccine then he/she will need to get two flu vaccines this season at least 28 days apart.

2. Has the person to be vaccinated today ever had an anaphylactic reaction to the influenza vaccine in the past?
   Yes No

3. Has the person to be vaccinated today ever had Guillain-Barr Syndrome?
   Yes No

My signature below signifies that I have received the Vaccine Information Sheet for the Influenza vaccine and/or COVID vaccine. I give my consent to have the influenza vaccine and/or the COVID vaccine administered to myself (if over 18) or to my child:

_____ _____ _____
Signature Printed Name Date

Relationship to Patient: _____

****If you are receiving the COVID Vaccine please fill out the COVID Pre Vaccination Form *****

For office use only:

FLU VACCINE: Dosage Given: .5mL Manufacturer: Sanofi Pasteur Lot # Exp:

Site administered: _____ Administered by (Initials): _____

COVID VACCINE: Dosage Given: 6mos to 4 yrs 5 yrs to 11 yrs 12 yrs +

Site administered:_____ Administered by (Initials): _____

Staff member completing task should initial when completed:

Ins/Demographics confirmed? _____ Entered in Chart: _____ Billed: _____ Scanned: _____