DATE: _____

OFFICE USE ONLY:

Charges on: _____ Posted $: _____ VFC $21.68 Charge: _____ Cash: _____x_____ $50.00 =: _____

****

Centennial Valley Pediatrics
Consent for Treatment

Name of Person receiving the vaccination: _____ Age: _____

Date of Birth: _____ Address: _____

City: _____ State: _____ Zip: _____ Insurance Name: _____

- If this person is a patient of Centennial Valley Pediatrics, we will bill the insurance on file.
- If you have new insurance, please have your card copied today at the front desk.
- For Parent Flu Vaccine Administration: We are unable to bill Parent and Non-Patient vaccines to insurance and do require payment today. The cost is $50.00. We accept cash, Visa, Mastercard and Discover. Please pay at the front desk PRIOR to receiving the vaccine.

The following questions will help us determine if you or your child should not receive the **Injectable Flu and/or COVID vaccine** today. If you answer "YES" to any question it does not mean that you should not be vaccinated, it means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

Please circle the vaccine(s) you would like your child to receive today: **Injectable Flu** **Injectable Covid**

FOR FLU VACCINE ONLY:

1. Is the person to be vaccinated sick today? Yes _____ No _____
2. Has the person to be vaccinated ever had a serious reaction to the Influenza or another vaccine in the past? If yes explain reaction: Yes _____ No _____
3. Has the person to be vaccinated ever had Guillain-Barre' syndrome? Yes _____ No _____

NOTE FOR FLU VACCINE ONLY:

1. If this is the **first** year your child is vaccinated with the flu vaccine and **through the age of 8 years** old your child will need a 2nd vaccine after 30 days. Initial _____

FOR COVID VACCINE ONLY:

1. Does the person getting vaccinated have a history of **COVID-19** disease within the past 3 months?
   Yes _____ No _____

   *If yes, we recommend waiting until 3 months have elapsed from the covid illness for best possible protection

2. Person receiving the Covid vaccine is between ages 6 months thru 11 years of age. Yes _____ No _____

I have read the above information about Injectable Flu and COVID vaccines and truthfully answered all questions. I have had a chance to ask questions and fully understand the benefits and risks of the Injectable. I agree that Centennial Valley Pediatrics shall have no responsibility or liability if I suffer any other adverse reaction following the administration of Injectable Flu.

Signature: _____ Date: _____

Please fill in Name and Date of Birth of Person receiving the vaccination on back side of form

Name of person receiving vaccination: _____ Date of Birth: _____

OFFICE USE ONLY:
NBrizuela,CMA CHamilton,CMA VJimenez,CMA JMelendez,CMA NPablo,CMA RPhillips,CMA CReta,CMA
DRodriguez,CMA JRose,CMA STorres,CMA
NMcKelvie,LPN APatzer,RN LScanlan,RN

FLU
Date Vaccination and VIS given: _____

VIS Date: Injectable Flu: 01/31/2025

Sanofi **PF** 0.5ml Flu Lot: _____ Exp: 6/30/26 Site: _____

COVID
Date vaccination and VIS given: _____

COVID-19 fact sheet date: 01/31/2025

Moderna 6 months-11 years: Lot: _____ Exp: _____ Site: _____

Pfizer 5 year- 11 year: Lot: _____ Exp: _____ Site: _____