Influenza Screening Form/ABN - Suburban Pediatrics

Last Name: _____ **First Name:** _____

D.O.B.: _____ **Age:** _____

Primary Insurance: **Circle One:** Medisource Community Care Child Health Plus Fidelis

Other: _____

Disclaimer: Vaccination eligibility is based on your answers to the following questions.

If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked

	YES	NO
1. **Is your child allergic to eggs or any component of the influenza vaccine?**	☐	☐
2. **Is your child ill today?** (Minor illnesses with or without fever do not contraindicate use of influenza vaccine)	☐	☐
3. **Has your child ever had a severe reaction to a previous dose of the flu vaccine?**	☐	☐
4. **Does your child have any history of Guillain Barré Syndrome, an illness associated with paralysis?**	☐	☐

Advanced Beneficiary Notice

Note: You will need to make a choice about receiving these health care items or services.

Your health insurance may not pay for the item(s) or service(s) that are described below. Health insurers do not necessarily pay for all of your health-care costs. Insurance only pays for covered items and services. The fact that insurance may not pay for a particular item or service does not mean that you should not receive it, especially if your physician recommends that you receive this item or service.

Description of Item(s) or Service(s)

Seasonal Influenza Vaccine • Estimated Cost: $50.00

The purpose of this notice is to help you make an informed choice about whether you want to receive these items or services, knowing that you might have to pay for them yourself. By signing below, you agree to take financial responsibility for the cost of the item(s) or service(s) in the event your health insurance does not include this as a covered item or service.

_____

Printed Name of Parent/Legal Guardian

_____ _____ / _____ / _____

Signature of Parent/Legal Guardian **Date**

_____ _____ / _____ / _____

Employee/Witness Signature **Date**

OFFICE USE ONLY

Stock	VFC
☐ **90685**: 6-35 months	☐ **90685V**: 6-35 months
☐ **90686**: 36 months and older	☐ **90686V**: 36 months and older
☐ **90460**: Flu Admin, Age 6 months – 18 years	
☐ **90471**: Flu Admin, Age 19 years & older	

Nurse Documented: _____ **Staff Charge Entry**: _____