FAMILY MEMBER
IMMUNIZATION/WAIVER/CONSENT FORM

Pediatric Services
4700 Park Glen Road
St. Louis Park, MN 55416

Please read the Vaccine Information Statement (VIS), complete the following questions, sign and date in the space indicated, and give the form to the front desk with your insurance card or payment before receiving your immunization or test. Please notify us with questions.

Name of person to receive immunization/test_____ DOB:_____
Mailing address:_____
Telephone:_____ Child's name:_____
Insurance:_____ ID#_____ GRP#_____

1. **In the past 10 days have you had a fever, cough, headache, sore throat, diarrhea or loss of taste or smell?**
2. **In the past 10 days have you been texted for Covid-19 or been exposed to Covid-19? _____**
3. **Are you sick today with a fever? _____**
4. **Is this person allergic to any medicines? _____**
   If yes, please list:_____
5. **Has this person ever had a serious reaction to previous vaccine? _____**

If you are wanting Flumist today, please answer these additional questions:

1. **Does this person have a serious allergy to eggs or egg products _____**
2. **Are you wheezing today? _____**
6. **Are you over age 49? _____**

Consent to Treat: I understand that the immunization or test does not constitute a "doctor-patient relationship," and I will seek medical advice from an appropriate health care provider with regard to the immunization or test. I consent to and authorize the physicians, nurses and other healthcare providers at Pediatric Services, PA to perform the above testing or vaccine.

I have read the VIS form and understand the risk and benefits of receiving this immunization. I hereby waive any claim for damages that I (or anyone claiming on my behalf) may have against Pediatric Services, PA, its member, employees, and agents on account of any injury or misfortune that I may suffer as a result of this immunization or test.

Assignment of Benefits/Payment for Services: I authorize payment of any and all benefits to Pediatric Services, PA. I know that I must pay for any charges for my care that are not covered by my insurance, health plan or government programs. I realize I must cooperate with Pediatric Services, PA to get payment for my care. If I am eligible for payment from more than one type of coverage, Pediatric Services, PA will return any extra payments to the payer. If I have an unpaid bill at Pediatric Services, PA, any refunds due to me will be put on my unpaid bill. If there is money left over after my bill is paid, I will get a refund from Pediatric Services, PA.

Patient Rights and Privacy Practices: You and your family's rights and our privacy practices are posted in main areas within Pediatric Services, PA. Your signature acknowledges receipt of our Notice of Privacy Practices. If you have any questions concerning your rights and/or our privacy practices, please request a copy from the front desk.

Signature_____ Date:_____