

All our Flu  
Vaccinations are  
Preservative-Free!

# TOUCHPOINT

PEDIATRICS, P.A.

## 2024 -2025 FLU SEASON VACCINE INFORMATION SHEET

Patient Name: \_\_\_\_\_  
Name Date of Birth

- Fluzone (the "flu shot") is recommended for virtually all people aged six months and older. Children's household contacts, out-of-home caregivers, and anyone who will be pregnant during the flu season is advised to get the vaccine.
- Children under nine years who are receiving Flu immunization for the first time, should receive two doses at least one month apart.

- I am refusing the flu vaccine on behalf of my child and fully understand the risks to my child and community.
- I have received the flu vaccine at another facility and will provide Touchpoint documentation for their records.

By signing below, I acknowledge I read the Vaccine Information Sheet. I/my child is healthy and does not have any condition that would prevent receiving Fluzone.

### Parent/Patient Please Check:

#### FLUZONE

- Patient did **NOT** have a severe reaction to previous flu vaccine.  Patient has **NOT** had Guillain-Barre Syndrome  Patient is **NOT** ill  Patient has **NO** fever

\*\*\* If you have any concerns about illness or immunizations, please make an in-office visit with one of our doctors \*\*\*

### FOR PATIENT:

I understand the information on the vaccine information sheet and that my insurance may not cover the Fluzone. Touchpoint Pediatrics will submit the charges to my insurance company for reimbursement. **IN THE EVENT IT IS NOT COVERED, I AGREE TO PAY TOUCHPOINT PEDIATRICS IN FULL FOR THE FLU VACCINE & ADMINISTRATION.**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Printed Parent/Guardian Name

\_\_\_\_\_  
Date

### FOR OTHER FAMILY MEMBERS:

I understand information on the vaccine information sheet and that I have the option to receive the Fluzone through my Primary Care Physician, and my Insurance may pay for it. Instead, I choose to have the vaccine administered by Touchpoint Pediatrics. I will pay in full. In the event my Insurance covers the vaccine, I agree to accept their payment. **I WILL NOT BE REIMBURSED THE DIFFERENCE BETWEEN WHAT MY INSURANCE COMPANY PAYS AND WHAT TOUCHPOINT PEDIATRICS CHARGES.** I received a copy of the Vaccine Information Statement. I understand if I have any complications or side effects, I will go to my own doctor.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Printed Patient Name

\_\_\_\_\_  
Date

### \*\*\*OFFICE USE ONLY\*\*\*

Administered: Lot Number: \_\_\_\_\_

CPT:  Preservative-Free Trivalent Fluzone 0.5 (>6mo) (90656)

Admin Code:  90460 IMM ADMIN<18YO  90471 IMM ADMIN>18YO

\_\_\_\_\_  
Clinician

\_\_\_\_\_  
Date

TAX ID: 223845047

#### AMOUNT PAID \_\_\_\_\_

DATE: \_\_\_\_\_  CHECK \_\_\_\_\_

CREDIT CARD  CASH

8.21.24

**\*\*\* MUST FILL OUT ONE SHEET FOR EACH VACCINE GIVEN \*\*\***

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