

**BLUE RIDGE PEDIATRIC & ADOLESCENT MEDICINE, INC**  
**Flu Vaccine Administration Form**

Patient's name \_\_\_\_\_

Date of birth \_\_\_\_\_ Age \_\_\_\_\_

Mother's maiden name \_\_\_\_\_

Insurance company \_\_\_\_\_

Please check one of the following regarding the above patient:

\_\_\_\_\_ 6 months to 59 months of age

\_\_\_\_\_ Has a sibling or lives in the household with someone 6 – 59 months of age

\_\_\_\_\_ Chronic medical condition (diabetes, asthma, cancer, cardiac, etc)  
Please specify \_\_\_\_\_

\_\_\_\_\_ Has a sibling or lives in the household with someone with a chronic  
medical condition  
Please specify \_\_\_\_\_

\_\_\_\_\_ None of the above applies

\_\_\_\_\_ My child is 24 – 27 months and I opt to purchase the FluMist vaccine at a  
cost of \$25.00 to be paid prior to administration.

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date

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Staff use only:

\_\_\_\_\_ 0.25cc                      \_\_\_\_\_ 0.5cc                      State              Private

\_\_\_\_\_ Flu Mist                      State              Private

Administrator's initials \_\_\_\_\_

\_\_\_\_\_ EMR

\_\_\_\_\_ NCIR

\_\_\_\_\_ NTP