I, _____, give permission for my child _____ to receive the 2017-2018 flu vaccination from a licensed representative from Walgreens pharmacy on (INSERT DATE HERE). I also confirm that my child is above the age of seven.

[.] I will provide my child with a copy of their insurance card.

[.] I will provide insurance information on this form:

BIN:

PCN:

RX Group:

ID Number:

Plan (example: Blue Cross Blue Shield of Mississippi)

[.] I will provide my child with cash or check made out to Walgreens for a total of $32.99

[.] My child is currently uninsured

PLEASE NOTE: In the event that your insurance does not cover the full amount of the 2017-2018 flu vaccine for any reason, by signing below you agree to reimburse. By not agreeing to the terms and conditions, you will asked to pay cash for the vaccine. <BR clear="none"><BR clear="none">

I certify that I am the patient's authorized representative and I have the legal right to obtain patient records.

Name: _____ Signature: _____Date:_____