The PEDIATRIC CLINIC
KIDS are at the heart of everything we do

Annual Influenza Vaccine Consent Form

Information about Patient to Receive Vaccine (please print)

PATIENT'S NAME (Last)	(First)	(M.I.)	**PATIENT'S DATE OF BIRTH**

Screening for Vaccine Eligibility

Please mark YES or NO for each question.

	YES	**NO**
1. Does patient have a serious allergy to eggs?	☐	☐
2. Does patient have any other serious allergies? Please list: _____	☐	☐
3. Has patient ever had a serious reaction to a previous dose of flu vaccine?	☐	☐
4. Has patient ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	☐	☐
5. Has patient had a vaccine within the last 4 weeks?	☐	☐
6. Has patient had a fever or been ill in the last 2 weeks?	☐	☐
7. Is the patient currently feeling ill?	☐	☐

CONSENT FOR INFLUENZA VACCINATION:
I have read or had explained to me the 2021-2022 Vaccine Information Statement for the seasonal influenza vaccine and understand the risks and benefits.

I GIVE CONSENT to The Pediatric Clinic and its staff to provide the above patient to be vaccinated with this season's influenza vaccine.

_____ _____
Signature of Patient or Parent/Legal Guardian Date

Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine	**Route**	**Date Dose Administered**	**Vaccine Manufacturer**	**Lot Number**	**Name and Title of Vaccine Administrator**
Influenza	☐ IM Location: Lt Deltoid Rt Thigh				