Flu Clinic Appt Time:

Pediatric Flu Vaccine Consent Form

Patient I.D._____

Patient Primary Care Dr. _____

I, _____, give consent for my child _____
PARENT/GUARDIAN NAME (PRINT)

D.O.B. _____ to receive the:

☐ Flu Mist – **Cannot have had MMR, VAR or MMRV within a month of getting Flu Mist (for ages 2yr – 49yr only)**

☐ Flu Shot- **Must be 6 months old.**

FOR CLINICAL USE ONLY

Lot Number _____ Exp _____

Administered By _____

The following questions will help us determine your eligibility to be vaccinated today. Please answer all questions.	**Yes**	**No**	**Don't Know**
• Do you have allergies to medications? (Examples: Gelatin, Gentamicin, Polymyxin, Neomycin) **If yes, please list the allergies:**			
• Have you ever had a serious reaction to an influenza vaccine?			
• Does your child have **EXCESSIVE ANXIETY** when getting an immunization? If so, it is recommended that this patient receive vaccine first.			
• Has your child gotten vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine:_____ Date given: _____/_____/_____			
• Does your child have any of the following: asthma, diabetes (or other type of metabolic disease) or disease of the lungs, heart, kidneys, liver, nerves or blood?			
• Does your child have a weak immune system (for example from HIV, cancer or medications such as steroids or those used to treat cancer?			
• Is your child pregnant? Last Menstrual Period Date: _____/_____/_____			
• Does your child have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?			

I UNDERSTAND THAT IF MY INSURANCE DOES NOT COVER THE FLU SHOT OR IF I AM UNABLE TO PROVIDE MY INSURANCE CARD, I WILL BE RESPONSIBLE FOR THE COST OF THE FLU SHOT*

_____ _____
SIGNATURE DATE

****

___ ***I decline*** the Flu Vaccination _____ _____
SIGNATURE DATE

Print Name_____