Flu Vaccine Consent Form

Patient I.D.\_\_\_\_\_\_\_\_\_\_\_

Patient Primary Care Dr. \_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give consent for my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT/GUARDIAN NAME (PRINT)

D.O.B. , Age (Yr.; Mo.)

to receive the flu shot.

**FOR CLINICAL USE ONLY**

Lot Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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** |
| 1. Do you have allergies to medications or any vaccine? (Examples: Gelatin, Gentamicin, Polymyxin, Neomycin) **If yes, please list the allergies:** |  |  |  |
| 1. Have you ever had a serious reaction to an influenza vaccine or any other vaccine in the past? |  |  |  |
| 1. Does your child have **EXCESSIVE ANXIETY** when getting an immunization? If so, it is recommended that this patient receive vaccine first. |  |  |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE DATE

🞏 I decline the Flu Vaccination \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE DATE