Flu Clinic Appt Time:

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:**			
2. Have you ever had a serious reaction to an influenza vaccine or any other vaccine in the past?			
3. 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