Influenza Vaccine Form

INFORMATION ABOUT CHILD RECEIVING VACCINE: Please Print

Circle: Male Female

Patient Name: ____
Last First Middle Initial

Patient Birthday: ____________________

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Possible contraindications to influenza vaccine for the Flu Shot:	Circle One:	
1) Is the child sick with a fever?	Yes	No
2) Does the child have a serious allergic reaction to eggs or gentamicin?	Yes	No
3) Has the child had any serious reactions to vaccines in the past, including Guillain-Barre Syndrome within the 6 weeks of receiving flu vaccine?	Yes	No

I have been given a copy and have had explained to me the information in the Vaccine Information Statement for the disease and flu vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and request the vaccine be give to the person named above for whom I am authorized to make this request.

I authorize the release of any medical or other information necessary to process this claim if billed to insurance. I agree to be financially responsible for any amounts not paid by insurance or other party.

______________________________ ____________________
Signature of responsible party Date Signed

For Clinic Use Only:

Vaccine Manufacture: ____

Vaccine Lot #: ______________________ Exp. Date: __________ Injection Site: ____________

______________________________ ____________ ______________________
Signature of Person Administering Vaccine Title Date Given

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