



## Consent for Influenza Vaccine Administration

**Patient Name** \_\_\_\_\_ **Date of birth** \_\_\_\_\_

**Please read and CHECK ALL BOXES below that apply:**

- I have read and understood the Vaccine Information Sheet explaining the benefits and risks of the 2020-2021 Flu Vaccine. <https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.html>
- I have had a chance to ask questions that were answered to my satisfaction.
- I ask that the 2020-2021 Flu vaccine, as circled below, be given to the child named above (for whom I am authorized to make this request):

### Flu Injection

### FluMist

<b>Please mark YES or NO for each question</b>	<b>YES</b>	<b>NO</b>
Has your child had a fever in the past 24 hours?		
Does your child have a severe allergy to eggs?		
Has your child ever had a serious reaction to a previous dose of flu vaccine?		
Has your child gotten vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: _____		
Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness)?		
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?		
Has your child been taking ASPIRIN? ( <b>Not</b> Tylenol or Motrin)		
Does your child have a weakened immune system due to disease (such as cancer or HIV/AIDS) or medical treatments (such as radiation, immunotherapy, steroids, or chemotherapy)?		
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 or received cancer treatments)?		
Is your child pregnant?		
<b>Does your insurance plan cover immunizations?</b>		
<b>Does your child have Medicaid?</b>		

**Explain yes answers here:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
**Parent Signature**

\_\_\_\_\_  
**Date**  
**MA/ MD initials** \_\_\_\_\_