



Flu Consent 2025-2026

PATIENT'S NAME: _____ DOB: _____ AGE: _____

Please circle **Yes** or **No** for the following questions:

1. Has your child had an allergic reaction to a previous flu vaccine or does your child have an allergy to a component (other than egg) of the flu vaccine?	Yes	No
2. Has your child developed Guillain-Barré syndrome within 6 weeks of a previous flu vaccination?	Yes	No
3. Is your child currently moderately/severely ill (with or without fever)?	Yes	No

If you answered YES, your child may not be able to receive influenza vaccine.

CHILDREN UNDER 9 YEARS OF AGE ONLY:

1. Prior to July 1, 2025 has your child ever received at least 2 other flu vaccines in their lifetime?	Yes	No
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If you answered NO to the above question, your child will need to receive a second dose of flu vaccine administered at least 28 days from now.

2. Has your child received a flu vaccine already this season (i.e. today would be the second dose)?	Yes	No
2b. If Yes: Has it been at least 28 days since last flu vaccine dose?	Yes	No

Statement of Consent/Waiver: "I have received and read the Vaccine Information Statement about the injectable flu vaccine. I understand that my insurance company may not cover the cost of the influenza vaccine. If they do not, I agree to pay \$35.00 to cover the cost of the vaccine."

Signature of Parent/Guardian _____ Date _____

Print Name of Parent/Guardian _____

Office Use Only: (Circle selections)

PRIVATE / VFC

Left / Right

Arm / Thigh

Please print initials clearly:

Vaccine Administered by: _____

Entered in eCW by: _____