Flu Consent 2024-2025

PATIENT'S NAME: _____DOB: _____AGE: _____

Please circle **Yes or No** for the following 2 questions:

1. Does your child have a history of Guillain-Barré Syndrome?	**Yes**	**No**
2. Has your child had an allergic reaction to a previous flu vaccine or does your child have an allergy to a component of the flu vaccine?	**Yes**	**No**

If you answered YES to any of the above questions, your child may not be able to receive influenza vaccine.

CHILDREN UNDER 9 YEARS OF AGE ONLY:

1. Prior to July 1, 2024 has your child ever received at least 2 other flu vaccines in their lifetime?	**Yes**	**No**

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: _____