

INFLUENZA VACCINE CONSENT AND ADMINISTRATION RECORD

Patient Name: _____ DOB: _____

Insurance: private medical assistance self-pay

Medical History Questionnaire:

1. Does your child have any allergies to egg or egg products: yes no
2. Does your child have any heart disease, kidney disease,
Cancer, diabetes, metabolic disease, sickle cell/blood? yes no
3. Does your child have asthma or cystic fibrosis? yes no
4. Does your child have a weakened immune system? yes no
5. Does your child have a neurologic condition or seizures? yes no
6. Is your child on aspirin therapy? yes no
7. Does your child have history or guillain-barre syndrome? yes no
8. Has your child had an allergic reaction to the flu vaccine? yes no
9. Is there any chance you/your child is pregnant? yes no

Past Flu History:

Has your child ever received a flu vaccine? Seasonal: yes _____ no _____ unsure _____

H1N1: yes _____ no _____ unsure _____

How many doses of flu vaccine did your child receive last year:

seasonal _____ H1N1 _____

Consent:

I have received and read the Vaccine Information Statement about the Influenza vaccine. I give permission for my child to receive the Influenza virus vaccine, given by the medical staff of Arundel Pediatrics. I recognize and understand that, as with all medical treatment, there is no guarantee that I will not experience an adverse side effect from the vaccine and I assume any risk.

Some Insurance policies do not cover the flu vaccine, or the administration of flu vaccines. I agree to be personally and fully responsible for payment.

X _____ Date _____