

CONSENT FOR INFLUENZA VACCINE

COTTON-O'NEIL CLINIC/ PEDIATRICARE

Doctor _____

1. Are you allergic to eggs or egg products, chicken, chicken feathers, chicken dander, mercury, thimerosal, or have severe latex sensitivity? yes no
2. Have you had a fever greater than 100⁰ F within the last 24 hours? yes no
3. Have you ever had a flu vaccine in the past? yes no
4. Have you ever had a reaction to the flu vaccine in the past?
If yes, describe _____ yes no
5. FEMALE ONLY: Are you pregnant? yes no
If yes: I have permission from my physician for the vaccine. yes

If You Have a Severe Reaction or one Lasting More than 24 Hours— See Your Doctor!

I have been given the CDC Vaccine Information Sheet dated 08-11-09.
I understand benefits and risks of influenza vaccinations as described.
I request that the vaccine be given to me or to the person named below for whom I am authorized to sign.

NAME: _____ Age: _____ Birthdate: _____
(PRINT)

ADDRESS _____
Street City State Zip

PHONE NUMBER: _____

X _____
SIGNATURE OF PERSON TO RECEIVE VACCINE DATE
(OR PARENT OR GUARDIAN)

(For Office Use Only)

Sanofi-Pasteur	Lot#U3175CA	🍏	GlaxoSmithKline	Lot#	<input type="checkbox"/>
[Exp. 6-30-10]	Lot#	<input type="checkbox"/>	[Exp. 6-30-10]	Lot#	<input type="checkbox"/>

Inj. Site: L deltoid
R deltoid
Other _____

Given by _____

Date _____