Pediatrics & Urgent Care

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Annual Influenza Vaccine Consent Form

FLU SHOT

Patient's Name: _____ DOB: _____ Age: _____

I have been offered a copy of the Vaccine Information Statement (VIS) for influenza vaccine. I have read, had explained to me and understand the information in the VIS related to influenza vaccine. I ask that the influenza vaccine be given to me or to the person named above for whom I am authorized to make this request. I consent to inclusion of this immunization data in the secure and confidential California Immunization Registry (CAIR) for myself or on behalf of the person named below.

INFLUENZA IMMUNIZATION SCREENING QUESTIONNAIRE		
1. Does the patient have a serious allergy to eggs?	YES	NO
2. Does the patient have any other serious allergies? _____	YES	NO
3. Has the patient had a serious reaction to flu vaccine in the past?	YES	NO
4. Has the patient ever had Guillain-Barré Syndrome?	YES	NO
11. Has the patient received vaccinations in the past 4 weeks?	YES	NO

Signature: _____ Date ___/___/_____

Name: _____ Relationship to patient: _____