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 meeical 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_____________________