

**Influenza Vaccine Questionnaire/Consent**

Your child is scheduled to receive the inactivated influenza vaccine today. Please complete the questionnaire and circle the appropriate answers for your child.

Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_years \_\_\_\_\_months (if under 1 year) Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| 1. Has the patient had any previous reaction to eggs or products containing? | YES | NO |
| 2. Is this the first time the patient is receiving the influenza vaccine? | YES | NO |
| 3. Has the patient ever had an allergic reaction to the influenza vaccine or any of its components (such as gentamycin, gelatin, or arginine) in the past? | YES | NO |
| 4. Is the patient experiencing any symptoms of illness or a fever today? | YES | NO |
| 5. Does the patient have any history of a seizure disorder? | YES | NO |
| 6. Does the patient have a history of Gillian Barre syndrome? (\*If yes, influenza vaccine cannot be given.) | YES | NO |

**If the answer to any of the questions 1 through 5 is yes, the patient will need to schedule an appointment with a provider before an influenza vaccine can be administered. If the answer to question 6 is yes, the patient CANNOT receive the influenza vaccine.**

**I hereby grant permission to South River Pediatrics to administer the influenza vaccine to the patient listed above. \*\*Consent can only be given by parents or legal guardians.**

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Print Name Relationship to Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**For office use only** Private \_\_\_ VFC \_\_\_

Lot #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LD RD RVL LVL

Expiration Date: \_\_\_\_\_\_\_\_\_\_ Initials of Administrator: \_\_\_\_\_\_