South River PEDIATRICS
We Care for Kids!

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.

_____ _____

Print Name Relationship to Patient

_____ _____

Signature Date

FOR OFFICE USE ONLY

Private ___ VFC ___

Lot #: _____ LD RD RVL LVL

Expiration Date: 6/30/2024 Initials of Administrator: _____